ORANGE COUNTY PHYSICIAN IPA MEDICAL GROUP, INC
DBA

NOBLE

COMMUNITY MEDICAL ASSOCIATES, INC. OF

MID ORANGE COUNTY

Provider and Group Management

Policy & Procedure Manual

Administrative Offices:

HealthSmart Management Services Organization, Inc.
5785 Corporate Avenue, Cypress, CA 90630-4726
Mailing Address: Post Office Box 6300, Cypress, CA 90630-6300

Toll Free: (888) 880-8811

Phone: (714) 947-8600 | Fax: (714) 947-8708

Revised: 08/2024

ORANGE COUNTY PHYSICIAN IPA MEDICAL GROUP, INC
DBA

NOBLE

COMMUNITY MEDICAL ASSOCIATES, INC. OF

MID ORANGE COUNTY

PROVIDER REFERENCE MANUAL

C/O: HealthSmart Management Services Organization, Inc.
5785 Corporate Avenue, Cypress, CA 90630-4726

Administrative Mailing Address:
Post Office Box 6300, Cypress, CA 90630-6300

Claims Mailing Address:
Post Office Box 6301, Cypress, CA 90630-0018

Toll Free: (888) 880-8811
Fax: (714) 947-8708| UM Fax: (714) 947-8700

Revised: 08/2024

Orange County Physicians IPA Medical Group, Inc.,

Dba NOBLE Community Medical Associates, Inc. OF MID ORANGE COUNTY

c/o HealthSmart Management Services Organization, Inc.
Mailing: Post Office Box 6300, Cypress, CA 90630-6300
Toll Free: (888) 880-8811 | Phone: (714) 947-8600 | Fax: (714) 947-8702

TABLE OF CONTENTS

SECTION 1: INTRODUCTION
Welcome
Health Network Description
Mission Statement
Program Descriptions
Primary Care Concept
Regulatory and Contractual Requirements
Provider Education and Training

SECTION 2: PROVIDER RESOURCES
Departments and Contact Information List
IPA Quick Reference Guide
In-Service Evaluation Form

SECTION 3: COVERED SERVICES
Perinatal Support Services (PSS)
Mental Health Services

SECTION 4: SERVICES COVERED BY OTHER AGENCIES
California Children Services
Whole Child Model *(CalOptima Only) formally known as CCS)*
Noble Whole Child Model Training
Alcohol Misuse Screening and Counseling (ASMC*) formerly Screening, Brief Intervention and Referral to Treatment for Alcohol Misuse (SBIRT)*

SECTION 5: PATIENT ELIGIBILITY VERIFICATION
Patient Eligibility
Patient Rights and Responsibility

SECTION 6: AUTHORIZATION AND REFERRAL GUIDELINES
Authorization for Medical Services
Referral Authorization Form and Direct Access Form
Second Opinion
Retroactive Authorization Request
Current Roster of Contracted Specialists
Oversight of Specialized DME Services

Emergency and Urgently Needed Services

SECTION 7: AUTHORIZATION PROCESS FOR LONG TERM CARE

Care Coordination Standards & Long-Term Support Services
Interdisciplinary Care Team for Medicare Special Needs Program Members

SECTION 8: CLAIMS AND BILLING GUIDELINES

Determining Which Claims Process Applies
Claims Processing Overview: Medi-Cal, Medicare Advantage, CFAD.
Electronic Claims Submission: Medi-Cal, Medicare Advantage, Cal Duals, CFAD Claim.
Hard Copy Claims Submission: Medi-Cal, Medicare Advantage, CFAD Claims Submitting Crossover Claims for Medi-Cal and Medicare (Medi-Medi) Members

SECTION 9: PHARMACY AND PRESCRIBER INFORMATION

Pharmacy Management Overview

SECTION 10: CASE MANAGEMENT

Case Management Program
Transplant Case Management
Coordination of Medicare and Medicaid Coverage
Interdisciplinary Care Team
Individual Care Plan for Case Management
2020 Special Needs Program (SNP) Care Management
Health Homes Program (HHP)
Noble Health Homes Program Training
Health Homes Community Resources
Community Resources

SECTION 11: COMMUNITY RESOURCES, SOCIAL AND SUPPORTIVE SERVICES

Women, Infant, and Children (WIC) Services

SECTION 12: QUALITY MANAGEMENT

Facility Site Review, Medical records Review and Physical Accessibility Review
Access Standards
Reporting Potential Quality of Care Issues
HEDIS Measures / HCC Reporting

SECTION 13: CREDENTIALING AND RE-CREDENTIALING

SECTION 14: MEMBER SERVICES

Member rights and responsibilities
Obtaining Assistance with Cultural and Linguistic Services
Accessing Interpreter Services
New Member Materials

SECTION 15: HEALTH EDUCATION

Health Education Services
Referrals to Disease Management

SECTION 16: COMPLIANCE

Fraud, Waste, and Abuse and HIPAA Training
Participation in Federal Programs Verification
Model of Care
Access and Availability
Fraud, Waste or Abuse-Investigating and Reporting

SECTION 17: PROVIDER RESPONSIBILITIES

Role of Primary Care Provider (PCP) Member Medical Record
Delegation Oversight for Facility Site Review Advance Directive
Doula Services Training
Dmentia Care Aware Cognitive Health Assessment Training

SECTION 18: PROVIDER COMPLAINT PROCESS

Provider Complaint Process
Time Limits for Filing
Required Documentation for Complaints
Time Frame for Resolution of Complaints: Non- Contracted Providers
Hearing Rights
Legal Claims and Judicial Review

SECTION 19: CALOPTIMA ADDENDUMS

1. Provider Resources
    - CalOptima Department and Program Contact Information
    - Provider Resources on CalOptima's Website

2. Covered Services & Services Covered by Other Agencies
    - Covered Services Overview
    - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
    - Hospice Service Referrals
    - Long Term Care Service Referrals
    - Multipurpose Senior Services Program (MSSP)
    - Long Term Services and Supports (LTSS)
    - Pediatric Preventive Services
    - Perinatal Support Services
    - Vision Services
    - Behavioral Health Services
    - Dental Services
    - Drug and Alcohol Abuse Services

- AIDS Waiver Services Referral
- Whole Child Model (WCM)
- Home and Community-Based Services Referrals
- Regional Center of Orange County Services

3. Eligibility Verification and Enrollment
    - Verifying Member Eligibility
    - Medi-Cal Recipients Not Enrollment in CalOptima
    - CalOptima's Medi-Cal and OneCare (HMO SNP) Member ID Card
    - Medi-Cal Share of Cost Members
    - Share of Cost for Long-Term Care Services

4. Authorization and Referral Guidelines
    - Wheelchair Authorizations and Repair Request
    - Non-Emergency Medical Transportation (NEMT) Requests
    - Incontinence Supply Information

5. Authorization Process for Long-Term Care (LTC)
    - Authorization Process for LTC
    - Initial Authorization: Skilled Nursing Facilities (SNF), Nursing Facility Level A (NF-A) and Level B (NF-B)
    - Reauthorization: Regular- Skilled Nursing Facilities (SNF), Nursing Facility Level A (NF-A) and Level B (NF-B)
    - Initial Authorization: ICF/DD, ICF/DD-H, ICF/DD-N
    - Reauthorization: ICF/DD, ICF/DD-H, ICF/DD-N
    - Initial Authorization: Subacute Adult and Pediatric
    - Reauthorization: Subacute Adult and Pediatric
    - Retroactive Eligibility: Authorization and Process Guidelines
    - Bed Hold and Leave of Absence: Authorization Requests
    - Deferred LTC Authorization Request Form (ARF)
    - Discharge Notification
    - Nursing Facility (NF) A- Level of Care Criteria
    - Criteria for Admission and Continued Stay-SNF
    - LTC ARF Process and Criteria: NF-A and Level B NF-B

6. Claims and Billing Guidelines
    - Other Health Coverage
    - Member Billing Restrictions

7. Pharmacy and Prescriber Information
    - Formulary Information
    - Pharmacy Prior Authorizations
    - Monthly Medication Limit
    - Medication Therapy Management Program
    - Medication use and Treatment Guidelines

- Pharmacy Network

8. Case Management
    - Complex Case Management
    - Case Management of Children with Special Health Care Needs
    - End-Stage Renal Disease (ESRD) Case Management
    - Hemophilia Case Management
    - Transplant Case Management
    - Referring Members for Case Management
    - Model of Care

9. Community Resources, Social and Supportive Services
    - Child Protective Services
    - Local Education Agency Services
    - Tuberculosis Directly Observed Therapy Services
    - Women, Infants and Children (WIC) Services
    - Coordination with Community Resources and Social Services

10. Customer Service
    - Assistance form CalOptima's Customer Services
    - Member Liaison Program for Senior and Persons with Disabilities
    - Health Network and Primary Care Provider (PCP) Selection
    - Member Rights and Responsibilities
    - New Member Welcome Materials
    - Obtaining Access to Cultural and Linguistic Services
    - Tips for Documenting Interpreter Services
    - Tips for Working with Interpreters
    - Tips for Working with Limited English Proficient (LEP) Members
    - Cultural Competency Training

11. Provider Responsibility
    - Role of the Primary Care Provider (PCP)

For more information and access to CalOptima's policies and procedures or provider manual, please visit the Provider section of CalOptima's website at www.caloptima.org.

INTRODUCTION



Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.

Welcome to Noble Community Medical Associates, Inc. of Mid- Orange County (Noble Mid OC)!

As a new or current member of our provider panel, we know you will have questions regarding our newly re-organized management; policies, procedures and patient care coordination and standards. We have prepared this manual to act as a reference to meet your needs and the needs of your IPA patients assigned to you through Noble Mid OC.

Your manual was prepared to be functional and to assist you in the preparation for Health Plan and regulatory agencies frequent audits. Please retain this manual and refer to it when you have any questions or issues. Updated information will be distributed frequently and we ask that you insert the updated material into this manual. We are here to assist you in achieving our mutual goals.

HealthSmart Management Services Organization, Inc.- Administration Office:

5785 Corporate Avenue
Cypress, CA 90630-4726

Tel: (714) 947-8600
Fax: (714) 947-8702 | UM Fax: (714) 947-8700

Mailing Address
P.O. Box 6300
Cypress, CA 90630-5050

Claims Mailing Address
P.O. Box 6301
Cypress, CA 90630-0018

The Administration Office is responsible for day-to-day operations in accordance with the policies and procedures established by Noble Mid OC's Board of Directors. Our management service for you include the coordination of:

Authorizations
Capitation Payment
Case Management
Claims Adjudication and Payment
Contract Management (Provider and Health Plan)
Credentialing and Re-credentialing
Disease Management
Eligibility Verification
Encounter Data
Health Education Coordination
HEDIS Collection and Coordination
Member Services & Grievances
Peer Review Coordination
Provider Services & Grievances
Quality Management
Utilization Management

Health Network/IPA Description



Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.
5785 Corporate Avenue | Cypress, CA 90630 | Toll Free: 1-888-880-8811

Orange County Physicians IPA Medical Group, Inc. dba NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY or Noble Mid-Orange County (Noble Mid OC) is dedicated to keeping you and your family healthy!

Noble Mid-Orange County has over 443 affiliated providers dedicated to your care. Noble Mid OC providers have a wide range of specialists and speak many languages to assist you with your health care needs. You may choose a provider that speaks English, Spanish, Vietnamese or Korean.

The physicians affiliated with Noble Mid-OC are a carefully blended mix of pediatric, general, internal and family practitioners, along with specialists who are all highly trained professional and experts in their field.

Noble Mid-OC's physician network provides compassionate care in a timely manner, is responsive to individual needs and values your participation in making your health care decisions. Noble Mid-OC's physician network is committed to the health and well-being of patients and places great value on building lasting relationships with you and your family.

Noble Mid-OC understands the local Orange County, Long Beach and Los Angeles communities. We welcome all members and we are committed to providing the beast care to our members.



Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.
5785 Corporate Avenue | Cypress, CA 90630 | Toll Free: 1-888-880-8811

NOBLE COMMUNITY MEDICAL ASSOCIATES OF MID-ORANGE hoặc còn gọi là Noble Mid-Orange County là một nhóm y tế quyết tâm giữ cho quý vị và gia đình luôn được khỏe mạnh!

Nhóm Y Tế Noble Mid-Orange County cộng tác chặt chẽ với hơn 443 bác sĩ, và những nhà cung cấp dịch vụ khác và họ là những người nói được tiếng Tây Ban Nha, tiếng Việt, và tiếng Đại Hàn cũng như là tiếng Anh để cho quý vị dễ lựa chọn.

Các bác sĩ cộng tác với Nhóm Y Tế Noble Mid-Orange County là một nhóm bác sĩ được lựa chọn kỹ lưỡng với nhiều ngành chuyên khoa khác nhau như bác sĩ nhi đồng, bác sĩ tổng quát, bác sĩ gia đình cũng như các bác sĩ chuyên khoa có nhiều kinh nghiệm trong lãnh vực chuyên môn của họ.

Hệ thống bác sĩ của Nhóm Y Tế Noble Mid-Orange County cung cấp các dịch vụ y tế trong thời gian thích hợp nhất, đáp ứng các nhu cầu cần thiết của quý vị, luôn tận tâm chăm sóc sức khỏe của bệnh nhân và chú trọng giá trị của sự liên hệ với quý vị và gia đình của quý vị.

Nhóm Y Tế Noble Mid-Orange County hiểu được sự đa dạng ở Quận Cam (Orange County), Long Beach, và Los Angeles. Chúng tôi đón tiếp tất cả các thành viên và chúng tôi quyết tâm mang lại sự chăm sóc đầy đủ phẩm chất cho các thành viên của chúng tôi.

Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.
5785 Corporate Avenue | Cypress, CA 90630 | Toll Free: 1-888-880-8811

Orange County Physicians IPA Medical Group, Inc., dba NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY or Noble Mid-Orange County se dedica a mantener a usted ya su familia sana!

Noble Mid-Orange County cuenta con mas de 443 proveedores afiliados dedicados a su cuidado. Noble Mid-Orange County proveedores tienen una amplia gama de especialidades que hablan muchos idiomas para ayudarle con sus necesidades de atencion de salud. Usted puede elegir un proveedor que hable ingles, español, vietnamita o coreano.

Los medicos afiliados con Noble Mid-Orange County son una mezcla cuidadosamente mezclado de practicante pediatrica, general y familiar, junto con especialistas que son profesionales y expertos capacitados en su campo.

Noble Mid-Orange County's red de medicos proporciona cuidado compasivo de una manera oportuna, es sensible a las necesidades individuales y valora su participacion en la toma de sus decisiones de atencion medica. Noble Mid-Orange County esta comprometido con la salud y el bienestar de los pacientes y pone un gran valor en la construccion de relaciones duraderas con usted y su familia.

Noble Mid-Orange County entiende las comunidades locales del Condado de Orange, Long Beach y Los Angeles. Damos la bienvenida a todos los miembros y estamos comprometidos a probar la major atencion a nuestros miembros.



Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.
5785 Corporate Avenue | Cypress, CA 90630 | Toll Free: 1-888-880-8811

오렌지 카운티 의사 IPA 의료 그룹, 주식, DBA NOBLE 지역 사회 의료 ASSOCIATES, INC.는 MID-ORANGE COUNTY 또는 귀족 미드 오렌지 카운티 건강한 당신과 당신의 가족을 유지하기 위해 최선을 다하고 있습니다!

노블 미드 오렌지 카운티는 치료에 전념 443 제휴 업체가 있습니다. 노블 미드 오렌지 카운티 제공 업체는 전문의 넓은 범위를 가지고 건강 관리 요구와 함께 당신을 돕기 위해 다양한 언어를 구사합니다. 당신은 영어, 스페인어, 베트남어 한국어를 구사 공급자를 선택할 수 있습니다.

노블 미드 오렌지 카운티에 소속 의사들은 모두 매우 자신의 분야에서 전문가와, 소아과, 일반 및 가족 종사자의주의 깊게 혼합 된그룹 입니다.

노블 미드 오렌지 카운티의 의사 네트워크, 적시에 간병을 제공 개인의 필요에 반응하고 건강 관리 의사 결정에 참여하고 있습니다. 노블 미드 오렌지 카운티의 의사 네트워크는 건강과 환자의 복지를 위해 최선을 다하고 당신과 당신의 가족과 지속적인 관계 구축에 큰 가치를 배치합니다.

노블 미드 오렌지 카운티 지역 오렌지 카운티, 롱 비치와 로스 앤젤레스 지역 사회를 이해합니다. 우리는 모든 회원을 환영하고 우리는 우리의 회원들에게 최적의 치료를 제공하기 위해 최선을 다하고 있습니다.

Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates Inc. of Mid Orange County
C/O HealthSmart Management Services Organization, Inc.

As you begin or continue treating patients and working with us, we hope you will continue to enjoy working alongside your other colleagues, interacting with new providers and meeting the challenges of the evolving managed health care environment. We wish you great success in your future and pledge to assist you in resolving questions and issues that we will be presented with.

Our Mission

Noble Mid OC is an Independent Physician Association ("IPA"). Noble Mid OC was developed as an IPA to managed CalOptima managed care Medi-Cal and OneCare members in Orange County.

Noble Mid OC offers services to patients enrolled in the CalOptima managed care Medi-Cal, and OneCare Program members in Orange County. The IPA Board of Directors is led by Noble Mid OC physician leadership. The IPA Board of Directors meets monthly to discuss and review financial status, operational issues, compliance, membership and contractual issues. The IPA Board of Directors is also responsible for establishing and overseeing the policies and strategic direction if the IPA.

Joint Operations Meetings are also regularly conducted among the IPA and CalOptima staff. These meetings provide an opportunity for discussions, updates of any concerns or issues that require attention and resolution.

Noble Mid OC Board of Director and Committees (Utilization Review, Quality Management, and Credentialing) also meet regularly to conduct and oversee the day to day business of the IPA.

Noble Mid OC also offers and conducts office manager and physician forums which focus on the individual needs of the physicians, their staff and patients.

Noble Mid OC services a significant number of CalOptima members. We ask that you and your staff please review the overview and mission statement"

> CalOptima is a managed health care program for people whom live and receive Medi-Cal and OneCare program benefits in Orange County. The State of California and the Orange County Board of Supervisors gave CalOptima the authority to manage these programs. The mission of CalOptima is to provide members with access to high quality health services delivered in a cost effective and compassionate manner.

Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates Inc. of Mid Orange County
C/O HealthSmart Management Services Organization, Inc.

Noble partners with several Health Plans in both Orange and L.A. County that provides several programs benefits for our members.

Benefits can include, but are not limited to:

- Physician Services
- Outpatient Care
- Emergency Services
- Urgent Care
- Durable Medical Equipment
- Laboratory Services
- Radiology Services
- Hearing Services
- Vision Services (Carve-Out)

For more details on additional benefits and what is covered, please contact your contracted Health Plans or IPAs.

Medi-Cal (Orange and L.A. County)
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 the 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 disease, disability, infirmity or impairment.

Covered California (L.A. County)
Covered California is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act (ACA). It is administered by the Department of Managed Health Care (DMHC). The ACA was designed to increase health care, reduce health care cost and improve affordability and improve people's health.

OneCare (HMO SNP) (Orange County- CalOptima)
OneCare is a 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 (have Parts A and B) and Medi-Cal, and who resides in Orange County can enroll into OneCare.

Medicare (HMO SNP) (Orange and L.A. County)
The program for Medicare (HMO SNP) is also provided by Medicare Advantage Plans within the Orange and L.A. County service areas.

Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.

PRIMARY CARE PROVIDER CONCEPT

Noble Mid OC Primary Care Providers (PCPs) help patients with a wide range of medical problems, including routine physicals, vaccinations and immunizations. They also make referral to specialist when needed. PCPs are licensed as General Practitioners, Internists, Family Practitioners, Pediatricians, and Obstetrician-Gynecologists (OBGYN's) that see patients of all ages, genders, or osteopaths.

Patients who establish rapport with a PCP obtain continuity of medical treatment thereby controlling costs. PCPs coordinate health care rather than having patients shift from specialist to specialist each time a different problem arises. PCP also can be more aware of how a problem relates to previous conditions a patient may have had, enabling then to render appropriate treatment. PCPs are schooled in the total patient care concept, rather than specialized care.

While specialists provide necessary consultations, PCPs are required to monitor and assess the actual treatment results on the patient as a whole. This reduces the necessity of follow-up visits to the specialist and thus controlling some of the costs. Specialty input is important, but total care is paramount and is continuously monitored by the PCP as to the impact on the patient as a whole.

Each patient assigned to Noble Mid OC (the IPA) must choose a PCP upon enrollment. The PCP will serve as the patient's personal physician and coordinate all aspects of the patient's care. This includes but not limited to: radiology, referrals to specialists, hospitals and ancillary services.

For these services, the PCP will be paid a monthly payment based upon the number of members assigned to their care. These payments will be calculated separately for each contracted Health Plan (please refer to your PCP Agreement with Noble OC). Pre-payment or capitation should be considered as payment in full for all capitated services. The PCP is entitled to collect the patient's co-payment pursuant to each patient's Plan benefits. Under no circumstance are eligible Plan (HMO or CalOptima) members to be billed for any covered, authorized service.

Capitation checks shall be calculated on a monthly basis according to your PCP Agreement with Noble Mid OC. Capitation checks shall be distributed monthly in accordance with the terms of your PCP Agreement.

Regulatory and Contractual Requirements

Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.

For inquiries on regulatory and contractual requirements please see your provider contract agreement.

For additional questions, please contact your Provider Services Department at:

Telephone: (888) 880-8811 or (714) 947-8600
Email: providerservice@healthsmartmso.com

You may also visit: http://noblemidoc.com/ or the health plan (CalOptima) at https://caloptima.org/ .

SUBJECT: Provider Education and Training **Policy #:** PR.2
DEPARTMENT: Provider Services

Effective Date: June 1, 2001
Last Revision Date: January 2021
Revised Dates: January 2026

SCOPE: This applies to All Line of Business

I. PURPOSE:

This policy outlines the initial and ongoing training and education requirements to providers regarding administrative and operational procedures and policies for compliance with IPA contractual, regulatory and statutory requirements in providing services to members.

II. POLICY:

A. All new contracted physicians participating in the IPA shall receive an in-service regarding administrative and operational procedures and requirements for the Medi-Cal, Medicare/ Medi-Medi, OneCare, Covered California Programs after the Credentialing Committee approves a new physician's credentialing. In-services shall be completed within thirty (30) business days of physician's credentialing approval date and activation date under the IPA. An initial in-service, which includes mailing of provider manual – "Welcome Packet" will be conducted within ten (10) business days.
All in-services, dates shall be documented, and at the end of the in-service/training, provider shall sign an acknowledgement notice indicating receipt of a complete provider manual and comprehension of the policies and procedures presented during the in-service. Training will include, at a minimum:

1. Health Plan programs and initiatives, including but not limited to the Whole-Child Model (WCM)/ California Children Services program and Health Homes Program;
2. IPA and Health Plan operations;
3. Provider Communications;
4. Members rights and responsibilities;
5. IPA policies and procedures;
6. Member benefits;
7. Claims submission and payment;
8. Critical Incident reporting;
9. Member Grievances and Appeals process;
10. Utilization Management Appeals and Provider dispute resolution process; and

11. Prior authorization process

B. IPA shall provide and disseminate additional ongoing training for contracted Providers:
   1. When determined necessary;
   2. Refresher training, on an annual basis, including but not limited to:
      a. Cultural competency training;
      b. SPD trainings;
      c. Fraud, Waste, and Abuse and compliance training;
      d. Model of Care;
      e. Participation in Federal Programs; and
      f. Access Standards
   3. When conducting Provider meetings and in-services/outreach visits; and
   4. Upon request from Providers.

III. PROCEDURE:

A. Credentialing Department

1. Upon the Credentialing Committee's approval of a new provider's credentialing application, a "Welcome" letter will be sent to the physician along with a copy of the executed Agreement with the IPA and a "Physician Office Manual - Quick Reference Manual."

2. The Credentialing Department will concurrently provide a copy of the welcome letter and approval date to the Provider Services Department.

B. Provider Services Department

1. Upon notification of the provider's approved status, the Provider Services Representative will schedule an in-service with the Provider, Office Manager and staff within the next ten (10) business days from Provider's placement on Active Status to review the administrative and day-to-day operational procedures and the forms required to obtain approval for and provide services to IPA members.

2. The Provider Services Representative will present the provider office with a Provider Manual containing forms, policies, procedures and protocols through which IPA will manage and work with physician to provide services to members.

3. The Provider Services Representative will review with physician, Office Manager and office staff the processes and requirements under the following areas of operations:

   a. Eligibility & Enrollment

b. Member Services

c. Utilization Management

d. Case Management

e. Claims

f. Provider Services & Contracting

g. Credentialing

h. Quality Management

4. In addition, the Provider Services Representative will provide forms that the offices are required to make available to Members, staff and physicians:

   a. Member Grievance & Appeals Form

   b. Provider Grievance & Appeals Form

   c. IPA Complaint, Grievance & Appeals Process

   d. Health Plan Grievance & Appeal Process

   e. State Fair Hearing Process

   f. Department of Corporations Grievance & Appeal Process

   g. Initial Health Assessment Forms

5. Upon completion of the in-service, the Provider Services Representative will obtain the provider's or provider's representative's signature on the "Check List and Acknowledgement Form" and/or "Provider Visit Form" indicating completion of education. A "New Provider In-Service Evaluation" survey will also be provided to the newly contracted provider to obtain feedback regarding the quality of the training.

IV. ATTACHMENTS:

A. Check List and Acknowledgement Form
B. Provider Visit Form
C. New Physician In-Service Evaluation

V. REFERENCES:

None

VI. DEFINITIONS:

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with the IPA. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within the IPA.
California Children's Services Program (CCS)	The public health program that assures the delivery of specialties diagnostic, treatment, and therapy serviced to financially and medically eligible individuals under the age of twenty-one (21) who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR). Sections 41515.2 through 41518.9.
Critical Incident	Refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Health Homes Program	All the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
Member	An enrollee-beneficiary of a CalOptima program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Whole Child Model Program (WCM)	Is CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child rather than handle CCS Eligible Conditions separately.

PROVIDER RESOURCES

HEALTHSMART MANAGEMENT SERVICES ORGANIZATIONS, INC.

Mailing Address: P.O. Box 6300, Cypress, CA 90630-0063

Tel: (714) 947-8600 Provider Services Fax: (714) 947-8708

CLAIMS MAILING ADDRESS*:* For EFFECTIVE DOS on and after 9/1/2023
P.O. BOX 6301 CYPRESS, CA 90630-6301
FAX NUMBER*:* (714)947-8725
EDI VENDOR: OFFICE ALLY - PAYER ID: HSM01

Provider Quick Reference Guide| IMPORTANT NUMBERS

DEPARTMENT	CONTACT	PHONE NUMBER	E-MAIL
Provider Services and Contracting Fax # (714) 947-8708	Jackee Bui, AVP	(714) 947-8608	jbui@healthsmartmso.com
	Sandra Rascon, Director	(714) 947-8740	srascon@healthsmartmso.com
	Dennis Valero, Manager	(714) 947-8612	dvalero@healthsmartmso.com
	Kaitlin Potter, Manager System Configuration	(714) 947-8756	kpotter@healthsmartmso.com
	Elvia Medina Support	(714) 947-5128	emedina@healthsmartmso.com
	Chetam Uma, Representative	(714) 699-5129	cuma@healthsmartmso.com
Member Services Fax # (714) 947-8705	Shelby Gresham,VP	(714) 947-8650	sgresham@healthsmartmso.com
	Sophie May, Manager	(714) 947-8653	smay@healthsmartmso.com
	Linda Jimenez, Supervisor	(714) 947-8654	ljimenez@healthsmartmso.com
Utilization Management Fax #'s Case Mgmt./Concurrent Review (714) 947-8782 UM (714) 947-8700	Michelle Olivas, VP of UM and Concurrent Review	(714) 947-8618	molivas@healthsmartmso.com
	John Duarte, Director of UM	(714) 699 -5124	jduarte@healthsmartmso.com
	Tracy Ortega Manager of UM	(714) 947-5969	tortega@healthsmartmso.com
	Anthony Ridley, Chief Strategic Operations Officer	(714) 947- 8737	aridley@healthsmartmso.com
Claims Fax # (714) 947-8725	Miriam J. Regalado, VP	(714) 947-8692	mregalado@healthsmartmso.com
	Luis Meza, AVP	(714) 947-8688	lmeza@healthsmartmso.com

Orange County Physician IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.

Mailing: Post Office Box 6300, Cypress, CA 90630
Phone: (714) 947-8600 | Fax: (714) 947-8708

QUICK REFERENCE GUIDE

IPA DEPARTMENT CONTACTS

Provider Services & Contracting (PSC) Phone: (714) 947-8600 | Press Option 6 Fax: (714) 947-8708 Email: providerservice@healthsmartmso.com *For Provider and Contracting Related Inquiries*	**Members Services (MS)** Phone: (714) 947-8600 | Press Option 1 Fax: (714) 947-8705 *For Member Eligibility and Member Related Inquiries*
Utilization Management (UM) Phone: (714) 947-8600 | Press Option 3 Fax: (714) 947-8700 *For Referral/Authorization Related Inquiries*	**Case Management (CM)** Phone: (714) 947-8600 | Press Option 5 Fax: (714) 947-8786 *For Member Case Managed Related Inquiries*

Claims
Phone: (714) 947-8600 | Press Option 2
Fax: (714) 947-8725
For Claims Related Inquiries

Claim Submissions (Mail)	Claims Submission (Electronic)	Appeals
P.O. Box 6301 Cypress, CA 90630-6301	Via Office Ally Payer ID Code: HSM01 *To set-up please contact Office Ally at: (866) 575-4120*	Attn: Claims Department P.O. Box 6301 Cypress, CA 90630-0018

WEB PAGES & RESOURCES

Noble Mid-Orange County Webpage:	http://noblemidoc.com/
Provider Online Web Portal:	https://secure.prod.hsmso.net/hsmso.net/login.aspx
Compliance & Health Plan Trainings:	http://healthsmartmso.com/

LABORATORY & RADIOLOGY VENDORS

For locations, please visit vendor websites for more information

Lab Vendor

LabCorp of America

https://www.labcorp.com/

Radiology Vendor

United Medical Imaging Healthcare

http://www.umih.com/

Noble-Mid Orange County
Protecting Your Family's Health
888.880.8811 www.nobleamidoc.com

Orange County Physician IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.

Mailing: Post Office Box 6300, Cypress, CA 90630
Phone: (714) 947-8600 | Fax: (714) 947-8708

QUICK REFERENCE GUIDE- Continuation

AFFILIATED HOSPITALS

Fountain Valley Regional Hospital & Medical Center	17100 Euclid Street Fountain Valley, CA 92708	(714) 966-7200

AFFILIATED URGENT CARE CENTERS

StrongKids Medical Group, Inc. 2222 S. Main Street Santa Ana, CA 92707 (714) 436-9999	**StrongKids Medical Group, Inc.** 12665 Garden Grove Blvd. Suite# 713 Garden Grove, CA 92843 (714) 537-6595	**Advance Urgent Care Medical Group** 1401 W. First St., Suite 101 Santa Ana, CA 92703 (714) 542-9700
Dusk to Dawn Urgent Care 3356 W. Ball Rd. Suite 120 Anaheim, CA 92804 (714) 828-2273	**Gateway Medical Group Urgent Care** 1006 W. La Palma St. Anaheim, CA 92801 (714) 778-3838	**Sunrise Multispecialist Medical Center** 867 S. Tustin Street Orange, CA 92866 (714) 771-1420
AME Medical Group, Inc. 11938 Paramount Blvd. Downey, CA 90242 (562) 923-6060	**AME Medical Group, Inc.** 8500 Florence Ave., Suite 101 Downey, CA 90240 (562) 202-5020	**AME Medical Group, Inc.** 3300 E. South St., Suite 209 Long Beach, CA 90805 (562) 444-0022
AME Medical Group, Inc. 12472 Washington Blvd. Whittier, CA 90602 (714) 451-2230	**AME Medical Group, Inc.** 3625 Martin Luther King Jr. Blvd. Suite 8 Lynwood, CA 90262 (323) 585-8876	

For more information regarding additional support, web portal access, demographic or notice of change requests, and more! Please contact Providers Services.

HealthSmart MSO, Inc.

10855 Business Center Drive, Suite C Cypress, CA 90630
Administrative Tel: (714) 947-8600, Fax: (714) 947-8708

PROVIDER IN-SERVICES

EVALUATION FORM

IPA Name: **Noble Community Medical Associates, Inc. of Mid-Orange County** ("Noble Mid-OC")

Provider Name:_____Date: _____

Your name/title/position: _____

☐ Physician ☐ Office Manager ☐ Other _____

Please note Physician's area of specialty:

☐ Family Practice ☐ General Practice ☐ Pediatrics ☐ Internal Medicine
☐ OB/GYN ☐ Other: _____

Overall evaluation of the in-service:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Do you feel this in-service met your expectations and needs?	☐ Very Well	☐ Somewhat	☐ Not at all	
Content of information received:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Did you understand the requirements and responsibilities indicated during the in-service?	☐ Very Well	☐ Somewhat	☐ Not at all	
Please rate presentation of materials provided:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Would you recommend this in-service to all new providers?	☐ Yes	☐ No		
Did you receive a Provider Manual?	☐ Yes	☐ No		

Comments: _____

_____

_____

Would you like additional materials? (list requested items): _____

_____

By signing below, I attest that an In-Service on the attached Agenda was provided to me/my staff:

Signature: _____ Date: _____

In-Service Performed by: _____

Orange County Physicians IPA Medical Group, Inc.
Dba Noble Community Medical Associates, Inc. of Mid Orange County
HealthSmart Management Services Organization, Inc.

This is to confirm that the below Provider has received a New Provider Orientation (NPO), Provider In-Service or Annual training. To ensure compliance, the Provider understands the discussed policies/procedures and Provider/Practitioner Manual (for applicable Health Plan), which contains additional contact information and describes in detail Health Plan's key policies and procedures by applicable line(s) of business.

☐ New Provider Orientation ☐ Provider In-Service ☐ Annual Training Year: _____

Provider Type (check applicable box):		**Line of Business (check applicable box):**	
☐ IPA PCP	☐ Specialist	☐ Medi-Cal	☐ Medicare
		☐ OneCare	☐ Commercial
		☐ All	☐ Covered Ca/Exchange

Topics

Information
- Provider Quick Reference Guide | Important Contacts
- Provider Demographic Information Submissions
- Access & Availability, Compliant with the After-Hours timeframe for response within 30 minutes & Sample Script
- Medi-Cal Managed Care Services/Program (HP Manual)
- Practice Guidelines (i.e., Participation in Federal Programs Verification Requirement, etc.)
- Reporting Requirements i.e., Encounter, HEDIS etc.
- Medi-Cal and Medicare Member Eligibility Determination and Verification Process

Case Management
- Case Management Referral – Contact
  Ailene Chou, RN, Director, Case Management
  (714) 947-5420
  achou@healthsmartmsmo.com
- Care Standards
- Continuity of Care
- Special Needs Plan
- California Children Services (LA County)/Whole Child Model (WCM)- applies to COHS Plans
- Long Term Services and Support (LTSS)- *Health Plan Responsibility*
- Behavioral Health
- Community Base Adult Services
- Critical Incident Reporting

Utlization Management
- UM Appeals and provider dispute resolution
- Prior Authorization Process and requirements

Initial Health Assessment (If Applicable)
- Staying Healthy Assessment (SHA)
- Medicare Annual Health Assessment (AHA)
- Individual Health Education Behavioral Assessment (IHEBA)

Cultural & Linguistic (C&L)
- Cultural & Linguistic Training
- Cultural Competency & Sensitivity training for Seniors and Persons w/Disability or Chronic Conditions
- Interpreter Services
- Customer Service
- Diversity, Health Equity and Inclusion Training
- Disability Awareness/Training Information including: awareness of personal prejudices and legal obligation to comply with ADA Section 504 of Rehabilitation Act, definition and concepts such as communication access, alternative formats, medical equipment access, physical access and access to programs, types of barrios encountered by target population, training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles and the recovery model.
- Work with Members with mental health diagnosis, including crisis prevention and treatment and substance use conditions
- Non-Discrimination requirements (i.e. HIV stigma)
- Use of culturally competent practices and access to services in a culturally competent manner for all members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56
- Lesbian, Gay, Bisexual, Transgender, Queer and /or Questioning, Gender Diverse Intersex, and Asexual (LGBTQIA+) cultural competent training;
- Responsibilities for Indian Health Care Providers and American Indian Members, Including:
  - Cultural Humility training
  - Overview of Trauma-Informed Care & Historical Trauma training
  - Other relevant trainings as noted by DHCS
- Quality Improvement for Health Services Program
  - https://www.caloptima.org/en/ForProviders/Resources/QualityImprovement
- https://healthsmartmso.com/wp-content/uploads/BlueShield-Advancing-Health-Equity-Training.pdf

Pay-For-Performance & Quality Program (If Applicable info will be provided)
- Medi-Cal HEDIS, Medicare Risk Adjustment
- Child Health & Disability Prevention (CHDP)

Claims Information (If Applicable)
- Claims Submission Information
  CLAIMS MAILING ADDRESS: P.O. BOX 6301
  CYPRESS, CA 90630-0018
  CLAIMS FAX NUMBER: (714) 947-8725

EDI VENDOR: OFFICE ALLY - PAYER ID: HSM01

- Appeal and Provider Dispute Resolution
- Electronic Fund Transfer (EFT)
- Member Billing Restrictions
- Medical Management Delegation and Payment Responsibility

Provider Resources

- **Web Portal:** Registration Form, User Guide, Eligibility, Claims, and Authorizations

Member Rights

- Members Rights and Responsibilities
- Member Services
- Appeals & Grievances
- Access & Availability
- Transportation
- Advance Directives
- Conflict Resolution
- Coordination of Benefits
- Member Benefits

Required Provider Trainings-http://healthsmartmso.com/

- Fraud Waste & Abuse, General Compliance, HIPAA Training
- Provider Manual – Noble
- Standards of Conduct/code of Conduct
- Participation in Federal Programs Verification (OIG/SAM)
- Medicare/MMP/D-SNP Model of Care Provider Training (If Applicable), Care Coordination, **NOTE:** *ICT training is done during onboarding and annually on an ongoing basis*
- Non-Contracted providers can review website at: http://healthsmartmso.com/ for training information and IPA protocols
- Additional training will be provided as defined by State Regulators (i.e., DHCS, CMS), the Health Plans, etcetera and will be noted in "other topic discussed" section below.
- CalOptima Policies and Procedures
- CalOptima/Health Network Operations
- Doula Training
- CalOptima Programs and Initiative
- Electronic Visit Verification Requirements and Reporting
- California Advancing and Innovating Medi-Cal (CalAIM) and the Whole-Child Model (WCM) program;
- Seniors and Persons with Disabilities Trainings (SPD)
- Critical Incident Reporting
- Dementia Care Aware Cognitive Health Assessment Training
- EPSDT Services
- Individual Health Education Behavioral Assessment (IHEBA) Contract Requirements
- Medi-Cal and Medicare Member Eligibility Determination and Verification Process Medical Management and Authorization Requirements

Checklist & Acknowledgement Form

Provider Communication new, modification, updates to policies, protocols, and services will be communicated to the provider network via blast fax and/or mailing.

Additional Provider Resources Provider Manual (s)

**Health Plan Provider Manuals are available by Health Plan, please refer to links listed below*:

- www.MolinaHealthcare.com.
- https://mediproviders.anthem.com/Documents/CACA_CAID_ProviderManual.pdf
- https://www.blueshieldca.com/provider/guidelines-resources/manuals/home.sp
- https://www.healthnet.com/portal/provider/home.ndo
- https://www.anthem.com/provider/policies/
- https://www.wellcare.com/en/California/Providers/Medicare
- https://www.centralhealthplan.com/cpa/Home/Contact
- https://caloptima.org/en/ForProviders/Resources/ManualsPoliciesandGuides.aspx

- REFER to Health Plan Provider Manual for Regulatory requirement Medi-Cal & Medicare (product lines of business). ALL marketing materials are required to be submitted to the appropriate regulatory agencies for approval.
- Out of Network Providers clinical protocols and guidelines shall be implemented at the time the IPA enters into an agreement with an Out of Network Provider

Other Topics Discussed (Indicate Below):

☐ Date In-service Conducted:
☐ New Provider Orientation
☐ Date Conducted: Annual

Provider Effective Date:
Group Name (if applicable)
Provider Name (Print):

Provider Signature (Required)
NPI:
Specialty:
Site Address:
City:
Zip Code:
Date Training completed

Authorized Staff Name (if Applicable):

Signature:

IPA Rep Name Conducted Training:



C/o: HealthSmart Management Services Organization, Inc.
Mailing Address: P.O. Box 6300
Cypress, CA 92630-0063
Tel: (714) 947-8600, Provider Services Fax: (714) 947-8708

Date

Provider Name
Address

Sent Via Fax:
& Certified Mail:

Re: Provider Training Attestation Training

Dear Valued Contracted Provider:

We are reaching out to you regarding your required scheduled provider training on _____*date*_____ which did not occur.

Per contractual guidelines, physicians under Noble Community Medical Associates, Inc. of Mid-Orange County are required to complete the necessary training to ensure you are properly educated on the process of the network and regulations of the health plans.

Please return the attached completed training no later than _____*date*_____ to ensure you meet network adequacy requirements

Should you have any questions, please contact Provider Services & Contracting Department at (714) 947-8600.

Thank you.

Sincerely,

On Behalf of Noble Community Medical Associates, Inc. of Mid-Orange County
HealthSmart Management Services Organization, Inc.

Jacob Sweidan, M.D. - President

cc: Noble Community Medical Associates, Inc. of Mid-Orange County – Board of Directors
Provider File

SERVICES COVERED BY OTHER AGENCIES

Noble Community Medical Associates, Inc. of Mid Orange County

California Children's Services (CCS)

Program Description

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (DHCS). Currently, approximately 70 percent of CCS-eligible children are also Medi-Cal eligible. The Medi-Cal program reimburses their care. The cost of care for the other 30 percent of children is split equally between CCS Only and CCS Healthy Families. The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families is funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds.

In addition, Insurance Code Sections 12693.62, 12693.64 and 12693.66, relating to the California's Healthy Families Program, provides that the services authorized by the CCS program to treat a Healthy Families plan's subscriber's CCS-eligible medical condition are excluded from the plan's responsibilities. The participating health plan's responsibility for providing all covered medically necessary health care and case management services changes at the time that CCS eligibility is determined by the CCS program for the plan subscriber. The health plan is still responsible for providing primary care and prevention services not related to the CCS-eligible medical condition to the plan subscriber so long as they are within the Healthy Families program scope of benefits. The health plan also remains responsible for children referred to but not determined to be eligible for the CCS program.

Included for your reference:

- Member Application to determine CCS Program Eligibility
- CCS Caring for Children with Special Needs

For more information on how to become a CCS Provider, Member Resources, and Medical Eligibility on, please visit:

- https://www.dhcs.ca.gov/services/ccs
- Local Los Angeles County: http://www.lapublichealth.org/cms/CCS.htm

Cite: 2020 Department of Health Care Services

- CCS Medical Eligibility Overview:https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx
- How to Become a CCS Paneled Provider: https://www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx

Cite: 2020 Department of Health Care Services

How do we apply?

Fill out a CCS application and return it to your county CCS office. You can get an application from your county CCS office or download from:
www.dhs.ca.gov/ccs

Fill out your application carefully so CCS will have all the information they need to see if you qualify.

Can a child apply for CCS?

If your child is 18 or older, or an emancipated minor they can apply on their own.

What if I need more information about CCS?

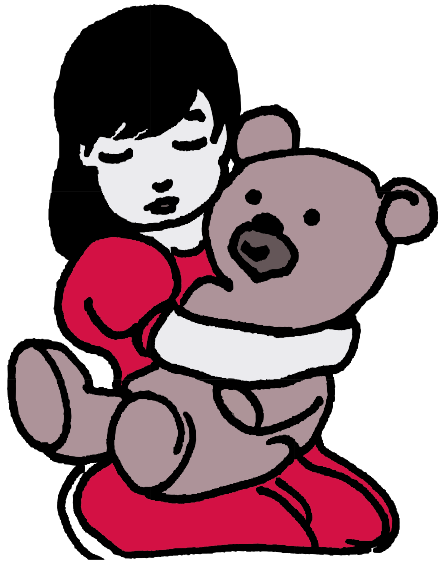
For more information, or help in filling out your application, contact your county CCS office. Find their address and phone number in the government section of your phone book. Look under *California Children's Services* or *County Health Department*.

Or, look for your CCS local office at:
www.dhs.ca.gov/ccs

Edmund G. Brown, Jr.
Governor, State of California

PUB 4 May 2003 English

California Children's Services



Caring for Children with Special Medical Needs

What is California Children's Services (CCS)?

CCS is a state program that helps children with certain diseases, physical limitations, or chronic health problems.



Can our child get CCS?

If you or your child's doctor think that your child has a medical problem that CCS covers, CCS can pay for an exam to see if CCS can cover your child's problem.

If CCS covers your child's problem, CCS pays for or provides services like:

- Doctor visits
- Hospital stays
- Surgery
- Physical and occupational therapy
- Lab tests and X-rays
- Orthopedic appliances and medical equipment.

What else can CCS do for our child?

CCS can manage your child's medical care. This means CCS can get the special doctors and care your child needs.

Sometimes, CCS refers you to other agencies, like public health nursing and regional centers so you can get the services your child needs.

CCS also has a Medical Therapy Program (MTP). MTPs are in public schools and give physical and occupational therapy to eligible children.

Are there other requirements?

To get CCS, your child must:

- Be under 21 years old; and
- Have or may have a medical problem that CCS covers; and
- Be a resident of California; and
- Have a family income under $40,000 (your adjusted gross income on the state tax form).

What if my family's income is more than $40,000?

You can still get CCS if:

- You have Medi-Cal (full scope, no cost);
- You have Healthy Families insurance;
- Your out-of-pocket medical expenses for your child's care is more than 20% of your family income;
- You only want MTP services;
- You need to see a doctor to see if your child is eligible for CCS; or
- You adopted your child with a known medical problem that made them eligible for CCS.

What medical problems does CCS cover?

CCS doesn't cover all problems. CCS covers most problems that are physically disabling or that need to be treated with medicines, surgery, or rehabilitation. There are other factors, too.

CCS covers children with problems like:

- congenital heart disease
- cancers, tumors
- hemophilia, sickle cell anemia
- thyroid problems, diabetes
- serious chronic kidney problems
- liver or intestine diseases
- cleft lip/palate, spina bifida
- hearing loss, cataracts
- cerebral palsy, uncontrolled seizures
- rheumatoid arthritis, muscular dystrophy
- AIDS
- severe head, brain, or spinal cord injuries, severe burns
- problems caused by premature birth
- severely crooked teeth
- broken bones

Can we use any doctor or provider we want?

No. CCS must approve the provider, services and equipment *first.*

INFORMATION ABOUT CALIFORNIA CHILDREN'S SERVICES (CCS)

What is California Children's Services?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with state CCS regional offices in Sacramento, San Francisco, and Los Angeles. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than $40,000 as reported on the adjusted gross income on the state tax form **or** whose out-of-pocket medical expenses for a child who qualifies are **expected** to be more than 20 percent of family income.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost.

What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and **some examples** of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genito-urinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care

• Disorders of the skin and subcutaneous tissue (severe hemangioma)
• Medically handicapping malocclusion (severely crooked teeth)
Ask your county CCS office if you have questions.

What must the applicant or family do to qualify?

Families (or the applicant if age 18 or older, or an emancipated minor) must:

• complete the application form on page 3 and return it to their county CCS office;
• give CCS all of the information requested so CCS can determine if the family qualifies;
• apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

How is my privacy protected?

California law requires that families applying for services be given information on how CCS protects their privacy.[1]

To protect your privacy:

• CCS must keep this information confidential.[2]

• CCS may share information on the form with authorized staff from other health and welfare programs **only** when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your county CCS office. By law, the information you give CCS is kept by the program.[3]

Do I have a right to appeal a decision?

You have the right to disagree with decisions made by CCS.[4] This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your county CCS office.

Where can I get more information about CCS?

For more information, or help in filling out this application, please contact your county CCS office. Their phone number is usually listed in the government section of your local telephone directory. Look under California Children's Services or county Health Department.

Notes
1 Civil Code, Section 1798.17
2 In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)
3 Section 123800 et. seq. of the California Health and Safety Code
4 California Code of Regulations, Title 2, Chapter 13, Sections 42702–42703

APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. Please type or print clearly.

A. Applicant Information

1. Name of Applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by

2. Date of birth (month, day, year)	3. Place of birth - county and state	Country, if born outside the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

5. Gender	6. Race/Ethnicity	7. Social security number (optional)

8. What is the applicant's suspected eligible CCS condition or disability?

9. Primary Care Physician	10. Physician's phone number

B. Parent/Legal Guardian/Family Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name

13. Residence address (number, street) (do not use a P.O. Box)	City	County	Zip Code

14. Mailing address (if different from 13)	City	County	Zip Code

15. Home phone number	16. Cell phone number	17. Work phone number	18. What language do you speak at home?
( )	( )	( )	

19. Email address	20. Number of persons in family unit

21. Other Parent Name and Address if not living with the applicant

C. Health Insurance Information

22. Does the applicant have Medi-Cal? ☐ Yes ☐ No	23. If yes, what is the applicants Medi-Cal number?	24. Is there a share-of-cost? ☐ Yes ☐ No	25. If yes, what is the amount you pay per month? $

26a. Does the applicant have other health insurance? ☐ Yes ☐ No	26b. If yes, what is the name of the insurance plan or company?	26c. Policy or Plan Number

27. Type of insurance plan or company
☐ Preferred Provider Organization (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other: _____

28. Does the applicant have dental insurance? ☐ Yes ☐ No	29. Does the applicant have vision insurance? ☐ Yes ☐ No

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

_____I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of applicant by the CCS program.

_____I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

_____I certify that I have read and understand the information or have had it read to me.

_____I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date

Signature of witness (only if the person signed with a mark)	Date

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHCS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office. Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next Box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. Box.
5. **Applicant's gender:** Place a checkmark or an X in the correct gender box (male or female).
6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

- Alaskan Native
- Amerasian
- American Indian
- Asian
- Asian Indian
- Black/African American
- Cambodian
- Chinese
- Filipino
- Guamanian
- Hawaiian
- Hispanic/Latino
- Japanese
- Korean
- Laotian
- Samoan
- Vietnamese
- White
- Other

7. **Applicant's social security number *(optional)*:** Please write the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Write the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's primary care physician:** Write the name of the applicant's physician.
10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.
13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. Box.
14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.
15. **Home phone number:** Please write the home phone number where you can be reached.
16. **Cell phone number:** Please write the cell phone number where you can be reached.
17. **Work phone number:** Please write the work phone number where you can be reached.
18. **Language(s) spoken:** Write the language you speak **at home**.
19. **Email address**: Write the email address for the parent or legal guardian.
20. **Number of persons in family unit:** Write the number of persons living in the same household.

21. **Other Parent Name and Address if not living with the applicant:** Write the name and address for a second contact person.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

22. If the applicant does not receive Medi-Cal, check "No" and go to number 26a. If the applicant receives Medi-Cal, check "Yes" and fill in the applicant's Medi-Cal number.

23. If you the applicant has Medi-Cal, enter the 14 digit Medi-Cal number.

24. If you pay a portion of the cost of your Medi-Cal insurance, check "Yes".

25. If you pay a portion of the chare of cost, fill in the monthly amount paid.

26a. If the applicant does not have other health insurance, check "No" and go to number 28.

26b. If the applicant has health insurance, fill in the name of the insurance plan or company.

26c. If the applicant has health insurance, fill in the policy or plan number.

27. If the applicant has health insurance, check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.

28. If the applicant has dental insurance, check "Yes." If the applicant does not have dental insurance, check "No."

29. If the applicant has vision insurance, check "Yes." If the applicant does not have vision insurance, check "No."

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

Submitting Your Application

Mail or deliver your application to your county CCS office. To find your county CCS office, go to www.dhcs.ca.gov/services/ccs or look in the government section of your local telephone directory under California Children's Services or county health department.

Noble Community Medical Associates, Inc. of Mid Orange County

Orange County (CalOptima Only)- Whole Child Model (WCM)- Formally California Children's Services (CCS)

Program Description

Senate Bill (SB) 586 authorizes the Department of Health Care Services (DHCS) to establish the Whole Child Model (WCM) program in designated County Organized Health System (COHS) or Regional Health Authority counties to incorporate California Children's Services (CCS) program covered services for Medi-Cal eligible CCS children and youth into a Medi-Cal managed care plan (MCP) contract. DHCS has developed a "Whole Child Model" to be implemented in 21 specified counties, no sooner than July 2018. The results are improved care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions. The benefits are consistent with CCS program standards and provided by CCS paneled providers, specialty care centers, and pediatric acute care hospitals. WCM approach meets the six goals for CCS Redesign:

- Implement Patient and Family Centered Approach
- Improve Care Coordination through an Organized Delivery System
- Maintain Quality
- Streamline Care Delivery
- Build on Lessons Learned
- Cost Effective

The approach is consistent with the primary goals of providing comprehensive treatment and focusing on the whole child, including the child's full range of needs rather than only on the CCS health condition.

There are 21 counties and 5 health plans that will participate in the WCM.

Included for your reference:

- Member Application to determine CCS Program Eligibility
- CCS Caring for Children with Special Needs

For more information on how to become a CCS Provider, Member Resources, and Medical Eligibility on, please visit:

- https://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx
- https://caloptima.org/en/ForMembers/Medi-Cal/WholeChildModel.aspx

Cite: 2020 Department of Health Care Services

- CCS Medical Eligibility Overview:https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx
- How to Become a CCS Paneled Provider: https://www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx

SUBJECT: Whole Child Model Program - California Children's Services **Policy #:** UM45
DEPARTMENT: Utilization Management

Effective Date: April 1, 2019
Last Revision Date: February 17, 2020
Last Review: January 2026

SCOPE:

This policy applies to CalOptima Medi-Cal.

PURPOSE:

Effective no sooner than July 1, 2019, CalOptima shall assume responsibility for California Children's Services (CCS) for Members who eligible and transitioned into the Whole Child Model program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification, evaluation and referral of Members with CCS eligible condition. Health Networks shall assume responsibility for coordination of determination of CCS eligibility and authorization in conjunction with CalOptima and the local CCS agency for potential CCS eligible medical services. This includes but is not limited to, authorization activities, claims processing, case management and quality oversight.

To ensure that all members who have California Children's Services eligible medical conditions are appropriately identified and referred to local CCS paneled providers for treatment.

To ensure members with a CCS eligible condition also receive services not related to their CCS eligible condition in a timely manner.

To ensure that a coordinated effort of referring for CCS services occurs between the Primary Care Physician, the UM Department, Case Managers and CCS Coordinators, CCS Providers and facility, CCS Case Manager, the member's assigned Health Plan Case Manager, and the member and/or member's representative.

POLICY:

The Whole Child Model Program is open to members who are less than 21 years of age and a resident of Orange County California or is applying for residence, that have a physical limitation or disease that is covered under the CCS condition list.

Current and applicable California Children's Services Program Guidelines, CCS Numbered Letters and county CCS Program Information Notices must be considered when requesting coverage for Whole Child Model [WCM] program. As part of the WCM, CCS eligible members will receive Case Management [See Case Management Program and Policies & Procedures].

Identification of member eligible for CCS coverage may come from the Health Network's Medical Management Department, including but not limited to Concurrent Review Nurses, Case Managers, UM Coordinators and CCS Coordinators, the Primary Care Physician, Specialists, Member Services, Claims and other community partners.

CCS eligible conditions information is located at:

a) https://www.dhcs.ca.gov.services/ccs/Pages/medicaleligibility.aspx
b) https://www.dhcs.ca.gov/services/ccs/Docuemnts/CCSMedicalEligibility.pdf

Staff will be in-serviced annually on the general conditions that meet eligibility for CCS coverage. Staff will have knowledge and adequate training on the Whole Child Program and must be able to identify and refer members with potential CCS eligible conditions to the local CCS program for CCS medical eligibility determination. CCS Case Managers will have clinical experience with either the CCS population or with complex pediatric medical conditions.

Members with a qualifying diagnosis will be identified and coded as CCS, referred to CCS paneled providers for services and a request for determination is submitted to CalOptima within 24 hours of identification. CalOptima facilitates communication with the local CCS Agency for determination of CCS eligibility and participation in the WCM.

As part of Concurrent Review, identification will be made for members who may be eligible for High Risk Infant Follow Up Program [HRIF] following an NICU admission. Coordination of NICU admission will occur in conjunction with CalOptima and/or local CCS Agency to determine member eligibility and coverage. Members determined to be eligible will be referred to a Case Manager at time of discharge. Continuity of care support, including notification to the local CCS Agency will be provided to any neonate and child up to age of 3, who lose eligibility coverage for HRIF within 15 days.

The PCP is responsible for providing a complete baseline health assessment and diagnostic evaluations to confirm or rule out a potential CCS eligible condition. If CCS eligibility is established, the PCP remains responsible for providing primary care services to the member, in accordance with CalOptima Pediatric Preventive Services guidelines, and coordination of services to ensure continuity of care.

The parent or caregiver of a CCS-eligible member may request a specialist or clinic as a primary care provider A CCS specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of CCS-eligible conditions of the CCS child or youth.

If the IPA does not have an active contract in place or the location of the specialist office does not meet the members need or cultural needs, the UM Coordinator will work with Provider Services to locate a specialist. In some cases, the UM Coordinator and Provider Services may identify and refer to a provider within the broader CalOptima provider network.

For Members eligible with the WCM program, Health Network must allow access to Out-of-Network providers in order to obtain Medically Necessary Covered Services, if:

- The Member or CCS-paneled provider follows Health Network's authorization policies and procedure to obtain appropriate approvals prior to accessing an Out-of-Network Provider; and
- Health Network has no specialist that treats the CCS-eligible Condition within the network; or
- In-network providers are unable to meet timely access standards, as described in CalOptima Policy GG.1600: Access and Availability Standards.
- Health Network cannot deny out-of-network services based upon cost or location.

- Health Network shall ensure transportation is provided for Members obtaining Out-of-Network Covered Services in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

CCS services are covered only from the time the referral is submitted to CCS, except for emergency services or services provided after hours. Referrals for emergency or after-hours care for potential CCS eligible conditions will be submitted to CalOptima for coordination with local CCS agency the next business day and must include appropriate documentation justifying emergency or urgent care.

All CCS eligible case will be referred to Case Management for care coordination.

The CCS Coordinator will maintain an ongoing log of all cases. The expiration dates for the CCS SAR will be monitored in conjunction with the Case Management process to ensure no gap in coverage for any WCM member with further medical needs. Requests and reporting of initial determination and annual redeterminations will be coordinated with CalOptima.

CalOptima will be notified of members transitioning into the Whole Child Model Program who develop additional CCS eligible conditions separate from the conditions known at transition and authorization process will be followed.

The Primary Care Physician, Medical Director, Specialist, Members and/or their representative may request an appeal of any case that is denied by the Local CCS Agency. Members will be provided information on the Grievance, Appeals and State Fair Hearing process. CalOptima maintains responsibility for coordination of Grievances and Appeals.

The Case Manager will monitor member eligibility with Medi-Cal and proactively coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the County CCS Program for ongoing health care and case management services.

DEFINITIONS:

California Children's Services (CCS) is a program that provides physical habilitation and rehabilitation for children with specific conditions. CCS sets forth the eligible specific conditions and guidelines for coverage of the condition. The goal is to obtain the medical and allied services necessary to achieve maximum physical and social function for children meeting these specific conditions. In most cases, the maximum age for eligibility is 21 years old.

Age- Out Transition and Planning: Process of identification and plan for members who will require long-term health care needs beginning at age 14 and again at ages 16, 17, 18, 20 and 20 and 8 months

Medical Therapy Unit [MTU]: Provides medically necessary physical and occupational therapy services for children with medically eligible physical disabilities at a medical therapy unit located on a public school campus. The MTU goals are the development of functional skills, independence and to improve the quality of life for both the child and their family.

Specialized and Customized Durable Medical Equipment: Wheelchairs [manual and power], wheelchair positioning systems and seating inserts, standers, gait trainers, walkers, adaptive strollers, shower/bath chairs and toileting equipment which meet all the following:

1. Is a uniquely constructed or substantially modified solely for use of the member;

2. Is made to order or adapted to meet the specified need of the member;
3. Is uniquely constructed, adapted or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

PROCEDURE:

Pre-Authorization Outpatient/Planned Services:

A. All referral requests initially screened by the UM Coordinator that appear to fall within the categories of medical eligibility for CCS will be coded as a potential CCS medically eligible case utilizing current and applicable California Children's Services Program Guidelines, CCS Numbered Letters and county CCS Program Information Notices.

B. Verification of CCS Paneled provider/facility will be determined and documented.

1. When request with a potential CCS eligible condition to a non-paneled CCS provider is received, designated staff will contact the PCP within 24 hours to verify if member's care can be transitioned to a CCS paneled provider.
2. If the IPA does not have an active contracted CCS paneled provider to meet the member's needs in a timely manner, the UM Coordinator will research the CalOptima CCS paneled provider list for identification of appropriate provider. If required, a Letter of Agreement will be initiated.

C. The referral will be processed through the usual UM Authorization process and will be reviewed by the Medical Director to determine need to refer case to CalOptima for CCS medical eligibility.

1. If the Medical Director determines the case does not meet CCS medical eligibility, the referral will be coded as a standard request and processed.

D. If the referral appears to meet potential CCS medical eligibility, within 24 hours or next work day the case will be coordinated with CalOptima and local CCS agency for CCS eligibility determination and acceptance in the Whole Child Program. Authorization should not be held pending CCS medical eligibility determination.

1. Documentation submitted for review, will include:

    a. A completed CCS program referral form
    b. Medical history with confirmation of medical condition and supporting medical information to confirm that a CCS eligible condition exists
    c. Description of services being requested
    d. Name of CCS paneled provider who will provide the requested services (if known)
    e. Name and telephone number of the referral source
    f. Completed CCS program application if available at the physician's office at the time of the referral

2. The CCS Coordinator may make daily / weekly calls to obtain a CCS Registry number and Service Authorization Request [SAR] number.

E. Communication of the final determination will be received come from CalOptima.

F. Notifications of final determination is sent to both the member and provider/facility.

1. If the determination is denied, the member and provider will be notified of their appeal rights.
2. The denial will be documented in the medical record and the code for CCS will be removed. The member will receive the standard notifications for approval of service where medically indicated under their Medi-Cal benefit.

G. The CCS Coordination will refer the case to Case Management.

Pre-Authorization for Specialized and Customized Durable Medical Equipment:

A. Request for Specialized and Customized DME may come from a provider or from the Medical Therapy Unit or Medical Therapy Program.

B. Members not participating in the Medical Therapy Unit [MTU] will be referred for a Home Assessment prior to approval for specialized and customized DME.

C. Payment will be at least equal to the applicable CCS FFS rates, as per regulation requires, unless otherwise agreed upon by the provider and CalOptima/ Health Network.

Concurrent Review:

A. As part of coordination for admissions, if a member is identified with a CCS eligible condition:

1. Verification of Facility and Provider's CCS paneled status will be determined, and case will be coded as CCS.

2. A request for determination is submitted to CalOptima within 24 hours of identification or next business day. CalOptima facilitates communication with the local CCS Agency for determination of CCS eligibility and participation in the WCM.

   a) Documentation submitted for determination will include a copy of the admission face sheet and current treatment plan with any available discharge plan needs from attending physician.

3. Members admitted to the Neonatal Intensive Unit may be coordinated with the High-Risk Infant Follow Up Program [HRIF].

B. Anticipated discharge needs will be referred to CCS paneled providers. Services that are not covered under the CCS condition will be coordinated and processed under the Medi-Cal benefit.

C. The Concurrent Review Nurse will refer the case to Case Management.

D. Communication of the final determination will be received come from CalOptima and attached to the medical record.

Retrospective Review:

A. Determination for CCS eligibility is performed on pre-authorization and concurrent services. If a case is identified on a retrospective basis, the case will be forwarded for determination of eligibility for on-going service needs.

B. Emergency services will be forwarded for determination on the next business day following notification.

Reporting of CCS activity:

A. Reporting of CCS activity will include, but is not limited to, according to CalOptima's Reporting Requirements:
    1. List of CCS paneled providers.
    2. Encounter activity
    3. Referral Activity
    4. Assessments of Care Coordination
    5. Continuity of Care Reports

FORMS:
Not applicable

REFERENCES:
Whole Child Model Program



Whole Child Model (WCM)

PROVIDER TRAINING

Course Content

- Overview
- Delivery Model
- Eligibility Verification
- Prior Authorization
- Continuity of Care
- Case Management- WCM Model of Care
- Claims Processing
- Resources

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions.
  - Locally administered by Orange County Health Care Agency

- The Department of Health Care Services (DHCS) is implementing WCM to integrate CCS services into select Medi-Cal Plans.
  - Effective July 1, 2019, CalOptima will implement WCM

WCM Goals

- Combine CCS and Medi-Cal services under one managed care plan
- Improve coordination of services to meet the need of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results
- Improve access to care

Division of WCM Responsibilities

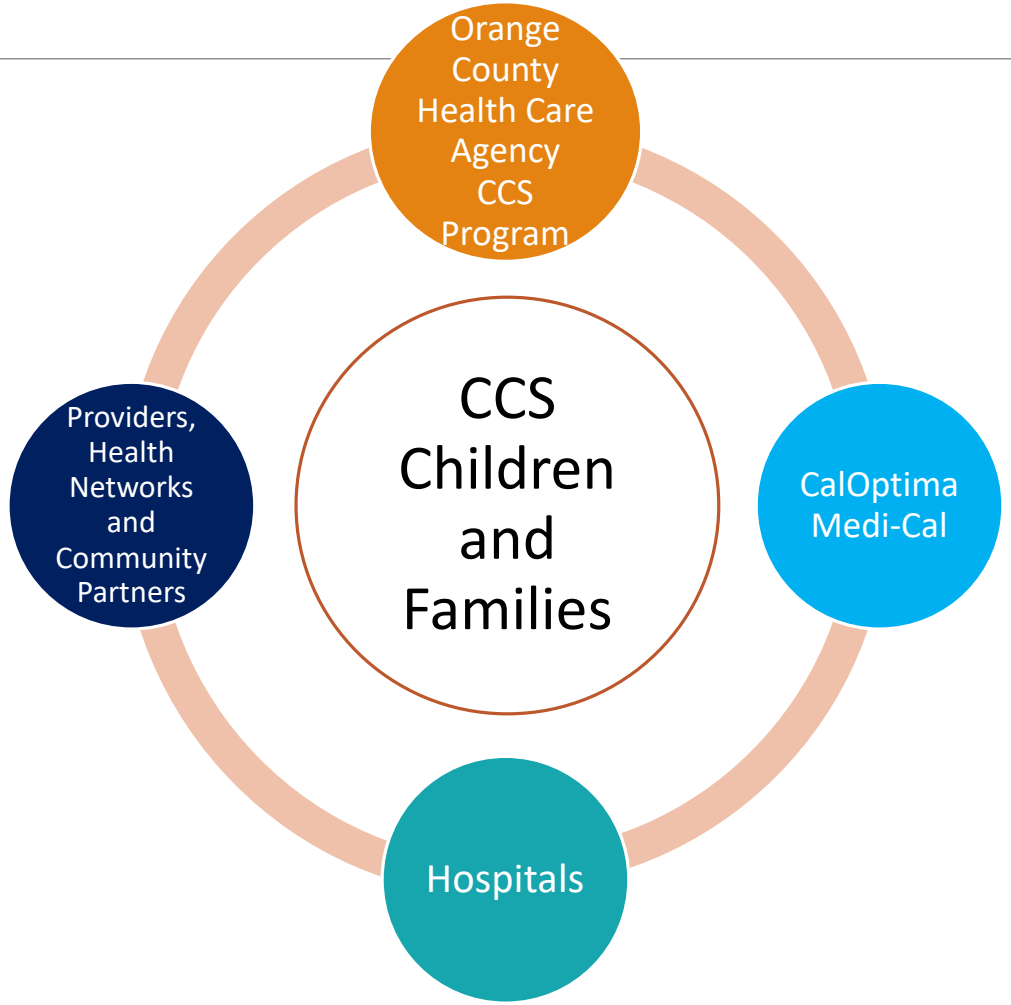
State
- Program guidance , oversight and monitoring
- Provider Paneling
- Claims payment for non-CalOptima children

County of Orange
- CCS Services for non-CalOptima children
- CCS eligibility
- Medical Therapy Program (MTP)

CalOptima
- Member notices
- Health Plan oversight
- Communication between the State, County of Orange, and Health Networks
- Initial Health Needs Assessment (HNAs)

Noble Mid-Orange County
- Provider Contracting
- Care Coordination
- Referrals and authorizations
- Claims payment (Professional)

Orange County Partners



CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - Ninety percent are CalOptima members

Languages	City of Residence (Top 5)
• English = 51 percent • Spanish = 42 percent • Vietnamese = 4 percent • Other/unknown = 2 percent	• Santa Ana = 23 percent • Anaheim = 19 percent • Garden Grove = 8 percent • Orange = 5 percent • Fullerton = 4 percent

Data as of April 2019

Guiding Principles: CCS Children

- Continuity of Care (CoC)
  - Members can request to continue seeing the same providers they currently see.
- Integration of services
  - Members receive CCS and non-CCS services under the same entity
- Member choice
  - Members can choose from a network of providers
- Timely access
  - Children receive timely authorizations and appointments

Guiding Principles: CCS Providers

- Broad participation
  - All existing CCS-paneled providers can participate under the new WCM.
  - Providers will have visibility to CCS and non-CCS services provided to member for them to coordinate care timely and with quality.

- Administrative simplification
  - Coordinating care under one entity will reduce the administrative burden.

- Stable payments
  - CCS paneled physicians will receive the CCS rate unless otherwise agreed upon.

Delivery Model

- Leverage existing delivery model using CalOptima and delegated Health Networks (i.e. Noble Mid Orange County)
  - Bringing together CCS services and non-CCS services into a single delivery system.

- Using the existing model creates several advantages:
  - Maintains relationship between CCS-eligible children, Noble Mid Orange County and the primary care provider.
  - Improves clinical outcomes and health care experience for members and their families
  - Decrease inappropriate medical and administrative costs.
  - Streamlines process for providers administering CCS and non-CCS services.

Noble Mid- Orange County and Primary Care Provider (PCP)

- Members can keep Noble Mid-Orange County as their assigned Health Network
  - Children with the following conditions will transfer to CalOptima Network on and after 07/01/19:
    - End-Stage Renal Disease (ESRD)
    - Hemophilia
    - Approved for transplant
- Members can keep their PCP
- Members can see CCS providers contracted with any CalOptima Health Network

Paneled Providers

- Physicians and surgeons must be paneled to provide services to members enrolled in CCS for CCS conditions
- DHCS requires other, but not all, provider types to meet CCS paneling requirements
  - Paneling is a process to determine if the provider meets education, training and/or experience requirements
  - DHCS will continue responsibility for paneling providers
    - CalOptima and Noble Mid-Orange County will validate paneling as part of contracting, credentialing and authorization processes, where required.

Other Providers

- DHCS requires hospitals, including NICUs, to be **approved** to provide CCS services, except in emergencies
- DHCS requires Specialty Care Centers (SCC) to be approved to provide CCS services:
  - SCC provide comprehensive, coordinated health care to children with certain complex, physically handicapping medical conditions
- A Full list of paneled and approved providers can be found on the DHCS website

Additional Information

- Noble Mid Orange County
  - Provider Services, Member Services, Case Management, & Utilization Management

    (714) 947-8600

- CalOptima

    (714) 246-8500
  - www.caloptima.org
  - WCM Stakeholders Page: https://www.caloptima.org/en/CCS_Info.aspx
  - WCM Member Page: https://www.caloptima.org/en/Members/Medical/WholeChildModel.aspx

DHCS Information

- DHCS WCM Implementation
  - Program information: http://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx
  - CCS Advisory Group: https://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

WCM Eligibility

- Before WCM:
  - Referrals to County to determine CCS eligibility
    - County works with providers to gather medical records to support eligibility determination
- Under WCM:
  - CalOptima will work with providers and Noble Mid-Orange County to gather medical records
    - Noble Mid-Orange County will send CCS referrals to CalOptima, and
    - County will coordinate with CalOptima if they receive an eligibility referral directly

<u>Note:</u> Members will continue to work with the Orange County Social Services Agency for Medi-Cal eligibility and annual redetermination.

Eligibility Verification

- Noble Mid-Orange County
  - Member Services: **888-880-8811**
- CalOptima
  - Customer Services: 714-246-8500
- State of California Beneficiary Verification System
  - Automated Eligibility Verification System (AEVS): 800-456-2387
  - Point of Services (POS) Device: 800-427-1295
  - Eligibility System: Department of Health Care Services
    - Website : www.medi-cal.ca.gov

WCM Services- Authorization

- Before WCM: Service Authorization Requests (SARs)
  - County authorizes CCS services in service code groupings
  - Allows any provider to bill a relevant procedure code under the service code group listed on the SAR

- Under WCM: CalOptima and Noble Mid-Orange County Authorizations
  - Under WCM, Noble Mid-Orange County will authorize individual services

WCM Services- Authorization (cont.)

- WCM authorizations requests are handled by Noble Mid-Orange County
- Medical necessity guidelines include CCS Number Letters
- Referral to CCS paneled specialists required for treatment of CCS conditions
- Prior Auth requests should include:
  - Diagnosis (ICD-10)
  - Service/Treatment being requested (CPT/HCPC)
  - Medical records to support the request

WCM Services- Authorization (cont.)

- Two ways to request Authorization(s):

  1) Provider web portal (PCP only)
     - www.healthsmartmso.com
     - Provider Login

  2) Fax Submission:
     - Authorization (Urgent & Routine) request(s) can be submitted via fax to: **714-947-8700**

WCM Services- Authorization (cont.)

- What is an URGENT Request?
  - "Urgent" request may **only** be submitted when the routine time frame* for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function.
  - Processed within 72 hours from the receipt of all information necessary to render a decision.
  - Forgetting to submit an authorization request does not make the request urgent.

* *Routine Time frame- five (5) working days within receipt of all information necessary to render decision; working days exclude weekends and state holidays.*

WCM Services- Authorization (cont.)

- Tertiary and Non-Contracted Providers
  - Non-contracted providers may be requested **only** if:
    - The service or specialty is not available in-network
    - Continuity of care- must meet very specific requirements (e.g. member transitions from fee-for-service (FFS) Medi-Cal while in a course of treatment)
  - Tertiary care requests are appropriate only if:
    - The complexity of the member's condition is such that it is unable to be managed by a community based, contracted provider
    - The rationale for tertiary provider care must be document on the request.

Continuity of Care (CoC)

- Under WCM, members can continue receiving any current **medically necessary services or prescriptions** if certain criteria is met:
  - CCS providers for CCS services for up to 12 months
  - Specialized or custom durable medical equipment (DME) provider for up to 12 months
    - May be extended if still under warranty and medically necessary
    - Prescribed drugs until no longer medically necessary
- Providers by submit authorization requests indicating this is a CoC request
- Members, family members or authorized representatives may also request CoC

Medical Therapy Program (MTP)

- The MTP provides occupational therapy and physical therapy to children enrolled in CCS
- Services are provided at one of 12 Medical Therapy Units (MTUs) in Orange County
- A Medical Therapy Conference (MTC) service is also provided
- The County will continue to be responsible for the MTP
- CalOptima and Health Networks will follow established processes for referring members to the County for MTP eligibility
- CalOptima and Health Networks will coordinate the administration of DME prescribed by the MTUs

Maintenance and Transportation (M&T)

- Separate from emergency, non-emergency medical transportation (NEMT), and non-medical transportation (NMT) benefits
- Available when costs are a barrier to accessing CCS services and no other resources is available
- Provides transportation and additional supports, such as parking, tolls, lodging and food
- Services may extend to additional family members
- CalOptima will be responsible for all WCM members
  - Limitations, criteria and authorizations apply

WCM Services- Case Management

- **WCM Model of Care**: CalOptima and Noble Mid- Orange County will follow its structured, time-tested approach to deliver coordinated, individualized care
  - Family and various members of the health care team collaborate on this “road map” to optimal health for each member enrolled in WCM
- An integrated delivery system that supports:
  - Care Management policies
  - Procedures
  - Operational Systems
- Personal Care Coordinators (PCC) (CalOptima and Noble Mid-Orange County) have a central role

WCM Services- Case Management (cont.)

- WCM Model of Care Process: Summary
  - Health Needs Assessment (HNA) completed for WCM member by CalOptima's PCC or registered nurse
  - Members are identified for one of the following Care Management Levels:
    - Basic
    - Care Coordination
    - Complex
- A case manager reviews the HNA, gathers additional information as needed and prepares an Individualized Care Plan (ICP)
- ICP for Care Coordination or Complex Case Management member is created by an interdisciplinary team

WCM Services- Case Management (cont.)

- Interdisciplinary Care Team
  - The care team is formed based upon the Member and family's needs. The care team may include:

Care Team Members	Ad Hoc Team Members
Member, Parent or Guardian	Social Worker
Personal Care Coordinator	Behavioral Health
Medical Case Manager	Special Care Center Staff
PCP	Medical Therapy Unit Therapist
Specialist(s)	Disease Manager/Health Educator
Pharmacist	Discharge Planner
Health Network (HN) Medical Director	

  - The Interdisciplinary Care Team is coordinated by the Member's HN

Aging Out- Transition of Care

- Transition planning for WCM members as needed
  - Planning can begin as early as age 14
  - Includes identification of ongoing needs and resources as well as future considerations
  - PCPs, Specialists, SCCs and MTP are vital in this process
  - Information about the age-out process will be provided to Members and their family as the transition approaches

- Transitions may occur for other reasons
  - Undocumented status (age 19)
  - Loss of Medi-Cal eligibility
  - Need to transition to an adult provider prior to aging out of WCM
  - CalOptima/HN will coordinate needs for these transitions as needed

Guardianship/Conservatorship

- Individuals appointed by the court to make certain decisions on behalf of others who are unable to do so
  - Guardians- healthcare and other mom-monetary decisions
  - Conservators- financial decisions

- Process
  - At age 17, a member's guardian will receive a notice from CalOptima encouraging them to discuss guardianship/conservatorship options with their child receiving CCS services
  - A case manager will provide a referral for services to the member and their family when the member turns 17
  - The member or family member to provide document guardianship/conservatorship, if applicable

Inter-County Transfers

- Definition:
  - Transition of care to or from another County
- Goal:
  - Allow for a seamless transition of care and records
- Process:
  - The County and the other County's CCS program will be responsible for transition members between counties
  - CalOptima will work with the County by providing or receiving the necessary medical information for the transfer

Case Management (cont.)

- Case Management Fax and Phone Number

FAX NUMBER	PHONE NUMBER
714-947-8796	714-947-8600

Claims Processing

- Claims and Provider Claims Disputes with **date of service prior to July 1, 2019** must be submitted to the County
- For inpatient claims with **admission date prior to July 1, 2019** must be submitted to the County
- Bill with appropriate codes and modifiers
  - Claims are subject to clinical editing and code validation
- Timely filing
  - Claims must be submitted within one (1) year from the date of service
- Prior authorization
  - Providers must obtain prior authorization for services or codes requiring authorizations

Claims Processing (cont.)

- Electronic Data Interchange (EDI)
  - Electronic Claims Submission for date of service or inpatient admissions dates July 1, 2019 and after:
    - Office Ally (OA) at 360-975-7000 press option #1
      Payer ID: HSM01

- Paper Claim Submission
  - Mailing Address:
    - Noble Mid-Orange County Claims Department
      P.O. Box 6301
      Cypress, CA 90630

Claims Processing (cont.)

- Provider Disputes Timeliness
  - Medi-Cal
    - Provider has 365 days from the initial approval/denial date to file
    - Noble Mid-Orange County has 45 working days (or 62 calendar days) to render a decision

- Provider has 180 days from first level provider dispute resolution (PDR) decision to file second level appeal with CalOptima's Grievance and Appeals department (GARS)

Claims Processing (cont.)

- How to Submit a Provider Dispute
  - Provider disputes should be submitted using the Provider Dispute Resolution Request form that when completed, provides all information necessary to resolve the disputed claim(s)
    - The Provider Dispute Resolution Request form is located under the "Claims Section" on HealthSmartMSO website.
- For multiple dispute submissions, the provider should attach a spreadsheet for all impacted claims to the Provider Dispute Resolution Request form.
- A copy of the original claim form is not necessary; however, when a correction is required, a corrected claim should be submitted with the dispute for consideration.

Claims Processing (cont.)

- How to Submit a Provider Dispute (cont.)
  - Provider disputes should contain all additional information needed to review a claim. This includes, but is not limited to, the following where applicable:
    - Hard copy of prior authorization
    - Proof of timely filing
    - Other health coverage remittance advices (RA/EOMB)
- Mailing Address for provider dispute forms
  - Claims Appeal Department

    P.O. Box 6301

    Cypress, 90630

Claims (cont.)

- Claims Department Fax and Phone Number
  - Customer service claims inquiries for claims with date of service of July 1, 2019 and after:

FAX NUMBER	PHONE NUMBER
714-947-8725	714-947-8600

Other Resources

- California Welfare and Institutions Code 14094.4-.20
- DHCS All Plan Letter 18-011: Whole Child Model Program
- DHCS CCS Guidance
  - https://www.dhcs.ca.gov/services/ccs
    - Publications (Manuals, Numbered/Information/HRIF letters)
    - Directories (CCS providers, Special Care Centers, NICU)
    - Becoming a CCS Provider
- CalOptima WCM Provider FAQ

Acronyms

- CCS- California Children's Services
- CMS Net- Children's Medical Services Net
- CoC- Continuity of Care
- DHCS- Department of Health Care Services
- DME- Durable Medical Equipment
- HNA- Health Needs Assessment
- ICP- Individualized Care Plan
- ICT- Interdisciplinary Care Team
- M&T- Maintenance and Transportation
- MTC- Medical Therapy Unit
- MTP- Medical Therapy Program
- MTU- Medical Therapy Unit
- NEMT- Non-Emergency Medical Transportation
- NMT- Non-Medical Transportation
- OC HCA- Orange County Health Care Agency
- PEDI- Provider Electronic Data Interchange
- SAR- Service Authorization Request
- SCC- Special Care Centers
- WCM- Whole Child Model
- WCMFAC- Whole-Child Model Family Advisory Committee


Protecting Your Family's Health
Noble-Mid Orange County
888.880.8811
www.noblemidoc.com

SUBJECT: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment [SABIRT] Policy # UM 42

DEPARTMENT: Utilization Management

Effective Date: July 2014
Last Revision Date: December 29, 2022
Last Review: January 2026

SCOPE:

This policy applies to all Medi-Cal lines of business

PURPOSE:

To ensure primary care requirement to provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) to members ages 11 years and older, including pregnant women.

All members 18 years and older responding yes to Alcohol Screening questions in Staying Healthy Assessment are given an additional expanded alcohol screening questionnaire.

To reduce the risk Alcohol misuse plays in a wide range of health conditions such as hypertension; gastritis; liver disease, including cirrhosis; pancreatitis; certain types of cancer, such as breast and esophageal cancers; cognitive impairment; anxiety; and depression.

POLICY:

Medi-Cal providers are required to complete an initial health assessment, which includes the age-appropriate history, physical examination and health education behavioral health assessment. Although plans must provide one alcohol misuse screening per year, additional screenings must be provided when medically necessary. Medical necessity must be documented by the member's PCP.

As part of the EPSDT requirement, PCPs are contractually required to provide services as recommended by the American Academy of Pediatrics (AAP) Bright Futures initiative for all members under 21 years of age. The AAP develops guidance and recommendations for preventive care screenings and well-child visits for children and regularly publishes updated tools and resources for use by clinicians and state agencies. Per AAP/Bright Futures recommendations, tobacco, alcohol, and drug use screening and assessment with appropriate follow-up action as necessary should begin to occur at 11 years of age. In providing SABIRT services, PCPs must comply with all applicable laws and regulations relating to the privacy of 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.

PCPs are also contractually required to provide all preventive services for members who are 21 years of age or older consistent with USPSTF Grade A and B recommendations. The USPSTF assigned a Grade B recommendation for Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults, as of November 2018, and for Screening for Unhealthy Drug Use, as of June 2020. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. Additionally, the USPSTF recommends screening by

asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. PCPs are also contractually required to provide all preventive services for members who are 21 years of age or older consistent with USPSTF Grade A and B recommendations. The USPSTF assigned a Grade B recommendation for Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults, as of November 2018, and for Screening for Unhealthy Drug Use, as of June 2020. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. Additionally, the USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

Effective January 1, 2014, the IPAs are responsible to cover and pay for an expanded alcohol screening for members 18 years and older who answer "yes" to the alcohol question in the Staying Health Assessment or at any time the provider identifies potential misuse of alcohol.

All members 18 and over who misuse alcohol will receive a counseling/screening in the primary care setting to impact risky drinking behavior, as well as potentially reduce injury or death as a result of such behavior.

Alcohol Use Disorder [AUD] is a mental health condition recognized by the Diagnostic and Statistical Manual of Mental Disorders (DSM), and as such, PCPs must provide mental health parity services for members screened and determined to have an AUD. Specifically, the Medicaid and Children's Health Insurance Program Managed Care Final Rule (CMS-2390-F)10 requires Medicaid Managed Care Organizations to provide coverage for certain benefits required under the Mental Health Parity and Addiction Equity Act of 2008, including Subpart K – Parity in Mental Health and Substance Use Disorder Benefits. As of October 2, 2017, MCPs are required to comply with the Mental Health Parity rule. The general parity requirement stipulates that financial requirements or treatment limitations for mental health benefits may not be more restrictive than the predominant financial requirements or treatment limitations applied to medical or surgical benefits

Each doctor's office is required to establish, implement and ensure that at least one supervising licensed provider per clinic or practice, and one trained non-licensed staff has received the minimum four-hour SABIRT Training. Training Attestations are a one-time requirement.

SABIRT trainings must be completed by December 31, 2014. Provider Services will maintain a copy of the PCP office attestations of the SABIRT training. At any change in staffing, the PCPs office will ensure the newly assigned staff receives required training.

Licensed Providers

Primary care physicians (PCPs), physician assistants, nurse practitioners, and psychologists who provide SABIRT services or supervise a trained, unlicensed health care provider in the provision of SABIRT services are required to comply with the following training requirements, at a minimum:

- For clinics or practices, at least one supervising licensed provider must complete four hours of SABIRT training within 12 months after initiating SABIRT services
    - Beyond the first 12 months of providing SABIRT services, at least one supervising licensed provider per clinic or practice must have completed training

Though not required, it is recommended that:

- All rendering licensed providers take training in order to provide SABIRT services
- For providers practicing alone, the provider complete four hours of SABIRT training within 12 months after initiating SABIRT services

Trained, Unlicensed Providers
Trained, unlicensed providers, including, but not limited to, health educators, certified addiction counselors, health coaches, medical assistants, and trained, unlicensed behavioral assistants, are required to comply with the following training requirements, at a minimum, in order to provide SABIRT services:

- Be under the supervision of one of the following types of licensed providers only:
  - Licensed physician
  - Physician assistant
  - Nurse practitioner
  - Psychologist

- Prior to rendering SABIRT services, complete a minimum of 60 documented hours of professional experience, such as coursework, internship, practicum, education, or professional work, within their respective fields. This experience should include a minimum of four hours of training directly related to SABIRT services, such as motivational interviewing

- Prior to rendering SABIRT services, complete a minimum of 30 documented hours of face-to-face client contact within their respective fields, in addition to the 60 hours of clinical professional experience described above. These contact hours may include internships, on-the-job training, or professional experience and SABIRT services training.

Behavioral counseling interventions for alcohol misuse vary in their specific components, administration, length, and number of interactions, but may include cognitive behavioral strategies, such as action plans, drinking diaries, stress management, or problem solving. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling.

The group must offer at least one, but may offer up to a maximum of three, behavioral counseling interventions for alcohol misuse per year. Additional behavioral counseling interventions must be authorized when medically necessary; however, medical necessity must be documented by the member's PCP.

PCPs must maintain documentation in medical records of the SHA and the expanded screening. When a member transfers to another PCP, the receiving PCP must obtain prior records. If no documentation is found, the PCP must provide and document this service.

Members meeting criteria will be referred to the alcohol and drug program in the county.

DEFINITION:

Alcohol Use Disorder: AUD is a chronic relapsing brain disease characterized by compulsive alcohol use, loss of control over alcohol intake, and a negative emotional state when not using.

Alcohol Misuse:

The United States Preventive Services Task Force uses the term "alcohol misuse" to define a spectrum of behaviors, including risky or hazardous alcohol use (e.g., harmful alcohol use and alcohol abuse or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion quantity of alcohol, resulting in increased risk for adverse health consequences (e.g., the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the U.S. Department of Agriculture define "risky use" as consuming more than four drinks on any day or fourteen drinks per week for men, or more than three

drinks on any day or seven drinks per week for women (as well as any level of consumption under certain circumstances).

The Centers for Disease Control and Prevention (CDC) Alcohol Team uses the following definitions of alcohol misuse:

Alcohol misuse

- For women, more than 1 drink per day on average
- For men, more than 2 drinks per day on average

Binge drinking

- For women, 4 or more drinks during a single occasion
- For men, 5 or more drinks during a single occasion

Excessive drinking includes heavy drinking, binge drinking or both

Alcohol misuse is a pattern of drinking that results in harm to one's health, interpersonal relationships or ability to work

Alcohol dependence, also known as alcohol addiction and alcoholism, is a chronic disease and is associated with experiencing withdrawal symptoms, loss of control, or alcohol tolerance.

Unhealthy Alcohol Use: The USPSTF uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for health consequences, but not meeting criteria for AUD.

Heavy Use: The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "heavy use" as exceeding the recommended limits of 4 drinks per day or 14 drinks per week for adult men or 3 drinks per day or 7 drinks per week for adult women.

Unhealthy Drug Use: is defined as the use of illegally obtained substances, excluding alcohol and tobacco products, or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual.

PROCEDURE:

A. Annually the group will educate Primary Care Physicians on the SABIRT requirements. Although plans must provide one alcohol misuse screening per year, additional screenings must be provided when medically necessary.

B. Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

• Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)

• Tobacco Alcohol, Prescription medication and other Substances (TAPS)

• National Institute on Drug Abuse (NIDA) Quick Screen for adults

Alcohol Use and Your Health

Drinking too much can harm your health. Excessive alcohol use leads to about 88,000 deaths in the United States each year, and shortens the life of those who die by almost 30 years. Further, excessive drinking cost the economy $249 billion in 2010. Most excessive drinkers are not alcohol dependent.

What is considered a "drink"?

U.S. Standard Drink Sizes



12 ounces
5% ABV beer



8 ounces
7% ABV malt liquor



5 ounces
12% ABV wine

(examples: gin, rum, vodka, whiskey)



1.5 ounces
40% ABV (80 proof) distilled spirits

Excessive alcohol use includes:

Binge Drinking

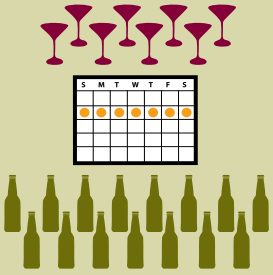
For women, 4 or more drinks consumed on one occasion



For men, 5 or more drinks consumed on one occasion

Heavy Drinking

For women, 8 or more drinks per week

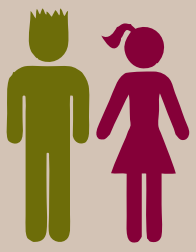


For men, 15 or more drinks per week

Any alcohol used by pregnant women



Any alcohol used by those under the age of 21 years



If you choose to drink, do so in moderation:



DON'T DRINK AT ALL if you are under the age of 21, or if you are or may be pregnant, or have health problems that could be made worse by drinking.

FOR WOMEN, up to 1 drink a day



FOR MEN, up to 2 drinks a day



NO ONE should begin drinking or drink more frequently based on potential health benefits.

National Center for Chronic Disease Prevention and Health Promotion
Division of Population Health

CS246270

Excessive alcohol use has immediate effects that increase the risk of many harmful health conditions. These are most often the result of binge drinking. Over time, excessive alcohol use can lead to the development of chronic diseases and other serious problems.

Short-Term Health Risks

Injuries
- Motor vehicle crashes
- Falls
- Drownings
- Burns

Violence
- Homicide
- Suicide
- Sexual assault
- Intimate partner violence

Alcohol poisoning

Reproductive health
- Risky sexual behaviors
- Unintended pregnancy
- Sexually transmitted diseases, including HIV
- Miscarriage
- Stillbirth
- Fetal alcohol spectrum disorders (FASDs)





Long-Term Health Risks

Chronic diseases
- High blood pressure
- Heart disease
- Stroke
- Liver disease
- Digestive problems

Cancers
- Breast
- Mouth and throat
- Liver
- Colon

Learning and memory problems
- Dementia
- Poor school performance

Mental health
- Depression
- Anxiety

Social problems
- Lost productivity
- Family problems
- Unemployment

Alcohol dependence

http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

MEMBER ELIGIBILITY

DETERMINATION AND VERIFICATION

Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid Orange County

PATIENT ELIGIBILITY

IMPORTANT: Before services are rendered to a Noble Mid OC Manage Care Patient or to any other HMO or PPO patient, your office must verify the patient's (member's) eligibility/ eligibility reports will be given to your office monthly. You must check eligibility to confirm membership.

DO NOT RELY ON A PATIENT'S MEMBERSHIP CARD TO DETERMINE ELGIBILITY. When the patient arrives at your office, request to see the Member's I.D. Card. Make a copy of their I.D. card and place it in the assigned location in the patient's chart. You should request to see their I.D. card at each visit.

METHOD OF VERIFING PATIENT ELGIBILITY

1. **Eligibility Lists:** Each Primary Care Physician will receive a list of all members assigned to their practice. Lists are alphabetically organized, some will be age banded and or aid code banded. Please notify Administration by telephone or fax if you have members that are assigned to you but are not on your eligibility list. Each Health Plan have specific guidelines on how they will accept transfer of members. Please refer to the index manual, which will explain each Health Plan's criteria for transferring members.

2. **Telephone verification:** Each Health Plan has dedicated telephone line so that your office can verify patient eligibility. Health Plan telephone numbers are usually listed on the backside of the patient's I.D. Card.

    a. HealthSmart Administrative Office: (714) 947-8600
    b. Anthem Blue Cross Member Services: (800) 407-4627
    c. Blue Shield Promise Health Plan Formally Care 1st: (800) 605-2556
    d. Brand New Day: (866) 255-4795
    e. CalOptima (Medi-Cal): (888) 587-8088
    f. CalOptima (OneCare): (855) 705-8823
    g. Central Health Plan (877) 412-2734
    h. Health Net Member Services: (866) 314-2427
    i. Molina Member Services: (800) 675-6110
    j. WellCare Health Plan Formally Easy Choice: (800) 526-8196
    (800) 960-2530

3. **The State of California Beneficiary Eligibility Verification System:** This is the preferred means of verifying member eligibility. This system providers up-to-date information

regarding current and retroactive member eligibility and offers the following option to obtain eligibility information:

- Medi-Cal Automated Eligibility Verification System (AVES)
  This system provides an Eligibility Verification Confirmation (EVC) number. AEVS can be accessed by calling (800) 456-2387 (must have a Personal Identification Number (PIN)).

- Point-of-Service (POS) Device
  This device offers a hard copy printout of the member's eligibility as confirmation. This printout can be used for documentation should a discrepancy arise regarding a Member's eligibility. To inquire about purchasing a POS device, please call (800) 541-5555.

- Medi-Cal Website
  This system allows providers to verify eligibility online at:
  https://www.medi-cal.ca.gov/eligibility/login.asp
  Providers must have a PIN to access these systems. Providers are given a PIN when they become certified Medi-Cal providers.

- Noble Mid-Orange County Member Services Department
  Providers may call our Members Services Department at (714) 947- 8600 to verify eligibility or to obtain answers to routine eligibility inquires.

Importance of verifying eligibility

If a member is not eligible for benefits on the date of service, the responsible health network will not pay the provider for rendered services.

If you cannot verify the patient's eligibility it is important that you should tell the patient that you are unable to determine eligibility at this time and that they will be financially responsible for their treatment until their eligibility is verified. Have the patient sign a Standard Financial Responsibility Patient Waiver form if you are unable to verify the patient's eligibility. Do not turn patient away from necessary care.

Orange County Physicians IPA Medical Group, Inc.
DBA Noble Community Medical Associates, Inc. of Mid- Orange County

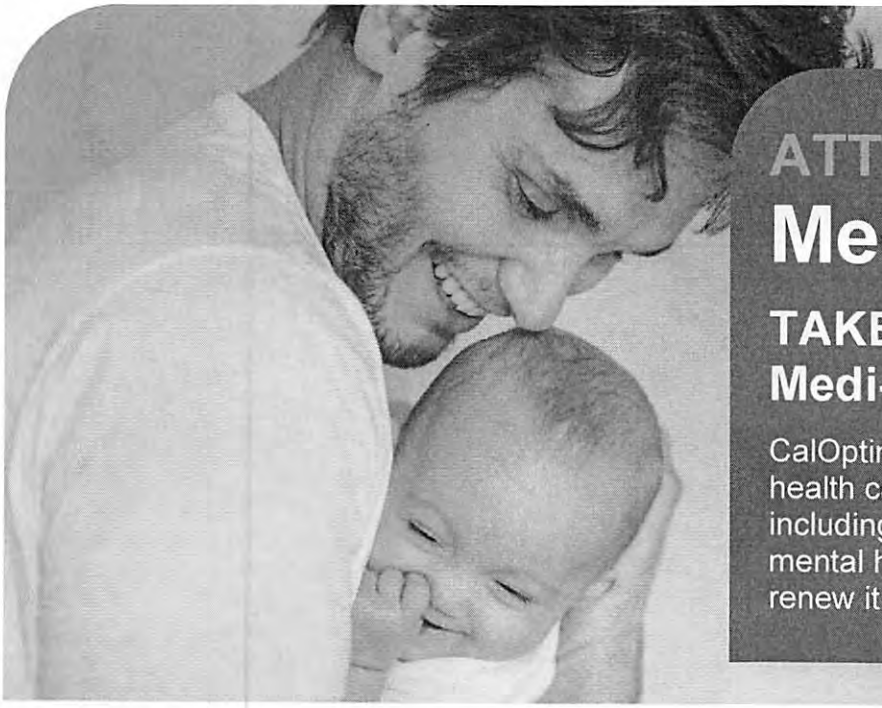
PATIENT RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHTS TO:

1. Dignified, courteous and considerate treatment by all staff
2. To have access to your medical records and have them kept confidential
3. To get information and communicate in the language that works best for you
4. To be informed about all health services that you can get
5. To say "no" to medical treatment
6. To receive preventative health services
7. To know and understand your medical problem and treatment plan
8. To receive an answer from your doctor when requesting special approval(s)
9. If you have an urgent condition, to receive an answer within 24 hours
10. To have a second opinion
11. To know when providers are no longer contract with your health network
12. To receive care from a certified nurse practitioner (CNP) and/or certified nurse midwife (CNM); and
13. To be told about procedures, including the complaint process with your health network and health plan and your right to file a State hearing

YOU ARE RESPONSIBLE FOR:

1. Knowing, understanding and following what is in your health plan's member handbook
2. Following the treatment plan your doctor/Primary Care Provider gives you
3. To tell your doctor/Primary Care Provider about your medical condition
4. To make and KEEP your appointments with your doctor/Primary Care Provider when you are sick, as well as tell your doctor's office when you must cancel your appointment
5. To learn about your medical condition and what keeps you healthy
6. To actively join in health care programs that keep you well; and
7. To be helpful and kind to the people who are partners in your health care



ATTENTION

Medi-Cal Members

TAKE ACTION to Keep Your Medi-Cal

CalOptima Health's Medi-Cal plan covers vital health care services for you and your family, including doctor visits, prescriptions, vaccinations, mental health care and more. Make sure you renew it when it's time.

Update your contact information

Report any new changes to your name, mailing address, email address and phone number, so the County of Orange Social Services Agency (SSA) can contact you. Call **1-800-281-9799**.

Create or check your online account

You can sign up to receive alerts about your Medi-Cal. Create or log into your account to get these alerts. You may submit renewals or requested information online. Go to **MyBenefitsCalWIN.org**.

Check your mail

SSA will mail you a letter about your Medi-Cal eligibility. You may need to complete a renewal form. If you are sent a renewal form in a yellow envelope, submit your information online, by phone, in person or by mail to avoid a gap in your coverage.

Complete your renewal form (if you get one)

If you receive a renewal form, submit your information within 60 days online, by phone, in person or by mail to avoid a gap in your coverage.

Right click here and select "Change Picture" to add your organization's logo.

Medi-Cal Beneficiaries:

Take action to keep your Medi-Cal

Your local county office will mail you a letter about your Medi-Cal coverage.



The letter will tell you if:

Your county needs information from you to renew your Medi-Cal

or

Your Medi-Cal was renewed automatically



If you get a renewal form, please fill it out and return it right away.

Check that your local county office has your updated information, including your name, current address, email address, and phone number.



For more details and to learn how to update your contact information, visit KeepMediCalCoverage.org

Medi-Cal

Beneficiarios de Medi-Cal

Actúen ahora para mantener su Medi-Cal

La oficina local de su condado le enviará una carta por correo sobre su cobertura de Medi-Cal.



La carta le dirá si:

Su condado necesita más información para renovar su Medi-Cal.

o

El condado renovó automáticamente su Medi-Cal.



Si recibe un formulario de renovación, llénelo y devuélvalo de inmediato.

Verifique que la oficina local de su condado tenga su información actualizada, incluyendo su nombre, dirección actual, dirección de correo electrónico y número telefónico.



Para más detalles e información acerca de cómo actualizar su información de contacto, visite MantengaSuMediCal.org

Medi-Cal

AUTHORIZATION AND REFERRAL GUIDELINES

Noble Community Medical Associates, Inc. of Mid-Orange County

SPECIALIST REFERRAL PROCESS

A **Referral Authorization Worksheet *(Attached)*** must be completed and approved by Noble's Utilization Management Department (UM) for all services outside of the Primary Care Provider's (PCP) contracted responsibilities for patients and services which are referred to a specialist physician.

It is the PCP's responsibility to see that all such care is coordinated. If the PCP sees a patient and determines that the patient requires specialty, ancillary or hospitalization, the PCP is responsible for arranging for these services. This is done by completing a referral form and submitting it to the UM Department at HealthSmart MSO.

Every effort should be made to refer a patient to those providers in which Noble is contracted with. If a provider is needed which is not on the provider roster, please contact HealthSmart MSO's UM department for further direction. All referral must be made by the PCP. All referral made by the specialist provider shall be reported to the PCP for input and follow-up review.

Utilization Management authorization review process requires that: When the PCP determines that a patient requires Specialty or Ancillary care, **the PCP is responsible for arranging for these services.** The PCP completes a referral authorization worksheet and submit (please fax to (714) 947- 8700) it to the UM Department. Routine or non-emergent care **must be authorized** prior to being referred.

The Medical Director is available for consultation. However, the UM coordinator can issue an authorization number for certain cases that meet clinical guidelines that have been approved by the UM Committee and Board of Directors. **Emergency care** may be referred directly to a contracted Specialist ort contracted Facility. Emergency care referrals will be reviewed retroactively by the UM Committee.

Referral Procedure: When a referral is needed, please complete a Referral Authorization Worksheet and fax it to the UM Dept. at Fax: **(714) 947-8700.** PCP's requesting specialist referrals will be notified by telephone, fax and/or mail, regarding approval/pended, modified or denied status, or if additional information is necessary to approve the request. If the request for referral is granted or not granted it is the PCP's responsibility to inform their patient and to continue arranging care. **Please ensure that you have:**

1) Checked member's eligibility
2) Checked request is a covered benefit
3) Clearly complete all information on referral request form; and

4) Attach/submit necessary documentation (i.e. chart notes, lab results, specialist consultation report) to assist the Medical Director's review and to accelerate your request.

The Referral Authorization Worksheet request very specific information. Please write legibly and be sure to supply all the information requested to avoid delay in the processing. Referral Authorization Worksheet should contain the following information:

1) Patient Information:
   - ✓ Patient's Full Name, Address, Telephone Number, Date of Birth, Health Plan, Member ID Number, Sex, and Date Submitted

2) Physician Information:
   - ✓ PCP's Name, Address, Telephone and Fax Number, Requested Specialist's Name, Type of Specialty, Address, Telephone and Fax Number, Date that you are filling out the referral request, Type and number of visits you are requesting

3) Level of Service:
   - ✓ All referral will be responded to within the following turnaround times:
     i. **Standard/Non-Urgent Referrals:** Within 2 days of receiving referral request
     ii. **Urgent Referrals:** Within 24 hours of receiving referral request
     iii. **Retroactive:** Within 30 days of receiving referral request

If a referral is submitted as Urgent, please state reason for urgent need.

All utilization decision regarding coverage and/or services must be based on appropriateness of care and services. The Medical Directors and/or Physician Reviewers will use one of the following criteria, but not limited to for referral determination:

- InterQual Criteria
- Apollo Guidelines
- Contracted Health Plan Policy Manuals and Clinical Criteria

The criteria used will be made available to all providers, members, and the public upon any written or verbal request. The information will be provided in a timely manner either via fax or mailing by contacting the UM Department at (714) 947-8600.

Noble does not reward practitioners, providers or employees for issuing denials of coverage or service. All denials must be strictly based on insufficient medical appropriateness or not a covered benefit. Financial rewards or incentives must not influence any utilization decision. Financial rewards or incentives may be issued to encourage efficient and appropriate care. To assure that the risks of underutilization are considered, no rewards or incentives can be issued that will discourage appropriate care and services to members.

In the event of a denial of service, you may contact the Medical Director to discuss the determination. Please contact the UM Department at (714) 947-8600 for further direction and phone number of the Medical Director.

4) Medical Information:
   Please indicate if this is a first consultation, follow-up (to include the number of requested visits), surgery, diagnostic, therapeutic, total OB care with last menstrual period or other type of service. The requested service and **requested date of service** and the facility you would prefer.

5) Diagnosis, Findings, and Symptoms:
   Include CPT-Code(s) and ICD-10 Code(s). Please include all information necessary that will be helpful to the UM Director/Committee in determining medical necessity of the requested referral, such as consult letters, progress notes, physical findings, lab, X-ray, and treatment trail reports.

6) Reason for Request:
   Previous treatment renders, length of treatment and results.

7) If the referral request is for an out of network provider, please give the name, type of provider, address, telephone and fax numbers, and contact person of the provider. Please include a clear and complete reason why an out of network provider is being requested.

NOTE: It is the PCP's responsibility to forward copied of medical records or test results to the Specialist. If the specialist request more tests or visits, they must notify your office and you must submit another referral request to the UM Department to include the specialist's consults notes with your request. A SPECIALIST MAY NEVER REFER A PATIENT FOR FURTHER CARE WITHOUT NOTITYFING THE PCP FIRST.

Examples of Referral Services Requiring Prior Authorization: Please refer to the following list of examples of procedures that you (the PCP) will generate to be approved by the Noble's UM Committee that require Prior Authorization. Referrals may include, but not limited to this list:

1) Audiograms- Please remember for the potential CCS eligible conditions, the PCP may perform the first two audiograms, then PLEASE send the third to a CCS approved provider

Consultation including:

2) Allergy
3) Cardiology**
4) Dermatology
5) ENT
6) Gastroenterology
7) General Surgery*
8) Infectious Disease
9) Neonatology
10) Neurology**
11) OB/GYN*
12) Oncology/Hematology**
13) Ophthalmology*
14) Oral Surgery
15) Orthopedic Surgery**

16) Pediatric Specialties
17) Perinatology
18) Plastic Surgery
19) Podiatry
20) Psychiatry
21) Psychology
22) Rheumatology
23) Urology*

* INITIAL consultations for members over 21 years of age, may be referred to the IPA's Capitated Provider** or Contracted Provider* (please refer to form) using the IPA's Direct Access Form.

24) Home Health Care, including: Home Health Nursing, Home Teaching, Lab Drawing, Patient Observation, Physical Therapy, Social Services, Infusion and Wound Care.

25) Cardiac Testing: ******Angiography, echocardiograms, Holter monitors, pacemaker checks, and treadmills

26) Durable Medical Equipment (DME), including: Medical devices and equipment, oxygen, pulmoaides, prosthetics

27) Hospitalizations for elective surgery

Please refer to the following list of examples of procedures that you (the PCP) will generate to be approved by the Angels IPA's UM Committee <u>that require Prior Authorization.</u> <u>Referrals may include, but are not limited to this list (Continued):</u>

28) Imaging Studies, including: Barium enemas, CAT Scans, Doppler Studies, GI Series, IVP, MRI's, non-routine X-rays, ultrasounds

29) Medical Treatments, including: Chemotherapy, chiropractic care, dialysis, pain management, physician therapy, speech therapy and occupational therapy, radiation treatment

30) OB Care: Amniocentesis, genetic testing, ultrasounds

31) Surgical procedures, including: in-office procedures and biopsies, inpatient elective surgery, outpatient surgery, tubal ligations

32) Invasive and Non-Invasive Procedures, including: Colonoscopies, cystoscopy, non-invasive cerebral, vascular flow tests, EEG, ENG, ERCP, escophageal manometry, liver spleen scan, ultrasound vascular, upper GI endoscopy, OPG, peritoneoscopy, PFT's

33) Mental Health, including (carved out for Medi-Cal): Coordination of inpatient detox, outpatient counseling, outpatient drug and alcohol rehab

34) OB/GYN Procedures, including: Cryocautery, biopsies, cervical cautery, colposcopy, hysterosalpinogram, laser treatment, office non-stress test, thermogram

List of Services that <u>DO NOT</u> Require Prior Authorization

The following list of procedures approved by Noble's UM Committee that DO NOT require Prior Authorization- *see* "Direct Access Referral Form" for additional information to the list of procedures:

1) Routine Lab Work at Contracted Laboratory(s)
2) Routine X-rays at Contracted Facility(s)
3) **Cardiology at Capitated Provider
4) *General Surgery at Capitated Provider
5) *Neurology at Capitated Provider
6) *OB/GYN at Contracted Provider
7) **Hematology/Oncology at Capitated Provider
8) *Ophthalmology at Contracted Provider
9) **Orthopedic Surgery at Capitated Provider
10) *Urology at Contracted Provider

* INTIAL consultations for members over 21 years of age, may be referred to the IPA's Capitated Provider** or Contracted Provider* (*Please refer to form*) using the IPA's Direct Access Form.

Noble's Medical Director and/or UM Review, reviews all routine and retroactive referrals on a daily (Monday-Friday) basis. Each referral is reviews and a decision is rendered based upon information that is presented by the PCP, patient's benefits and appropriateness of care. Action is taken on every request. Descriptions of the possible actions and general instructions for the PCP follow-up are:

APPROVED: Approval form with an Authorization Number is returned to the PCP. A copy is forwarded by mail to the approved specialist and patients. It is the PCP's responsibility to contact the patient and direct them to arrange for an appropriate appointment.

APPROVED AS MODIFIED: Referral is approved, but the requested provider or treatment plan was modified. If the services are approved but the UM Director or Medical Director feels the specialist/facility requested should be elsewhere, the referral is marked "MODIFIED" with an explanation of modification.

DENIED: A statement of the reason for denial will be presented to the PCP, The PCP determines future actions. Denial reasons may be because the service requested is not a covered service/benefit, under capitation, or Health Plan responsibility, lack of eligibility of the patient, or not medical indicated. The patient will be informed by mail that he/he is financially responsible for the referral costs; if they chose to pursue the PCP's suggested course of treatment. If the PCP does not agree with the denial the PCP may submit a letter stating the reason for dispute to the UM Department within 24 hours for a second review. If the PCP agrees with the denial decision, a letter will be mailed to the patient to inform them of the denial. This letter must be sent within 5-days of the referral processing time. The denial letter will contain information of the patient's grievance

rights if they disagree with the denial of the referral. All Denied requests are reviewed at the UM Committee Meeting.

DEFERRED: A description of the reason for Deferral is presented to the PCP. Deferred status may be the need for additional information or may indicate alternative treatment panels for the PCP to consider. It is the PCP's responsibility to determine the course of treatment by submission of additional information or alternative treatment plan.

REPORTS OF REFERRAL FINDINGS GO DIRECTLY TO THE PCP.

Specialist Referral. If a patient is unable to complete the treatment in the number of authorized visits, a detailed report that includes diagnosis, treatment plan and prognosis should be submitted by the specialist in writing to the referring PCP. It is then the PCP's decision as to the next step in the treatment plan. The PCP may submit an additional request to the UM Director or Medical Director or it may be appropriate for the PCP to assume continuity of care.

In most cases, it is appropriate for the PCP to request a "Consult Only" and to review and pursue the patient's care on the consultation recommendations.

SPECIALIST CANNOT GENERATE A REFERRAL:

The PCP must determine if additional visits, other procedures or admission to the hospital is necessary and must submit a request to the UM Committee. Specialist should not schedule follow-up appointments until authorizations for such appointment has been received. Retroactive authorizations for appointments WILL NOT be approved for non-emergent cases.

Under no circumstances should a specialist physician continue seeing a patient without prior authorization. Unauthorized services will not be approved for payment by Noble.

SUBJECT: Referral Authorization Process **Policy #:** UM4
DEPARTMENT: Utilization Management

Effective Date: June 14, 1997
Last Revision Date: July 2, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To outline the UM program method of reviewing, authorizing, modifying, and denying all requested healthcare services. To ensure timeliness of the process in compliance with NCQA, regulatory agencies and health plans.

POLICY:

The Utilization Management Committee oversees the development and implementation of an effective referral authorization process for all ambulatory, hospital, and ancillary referrals.

Appropriately licensed professionals will supervise all medical necessity decisions. Medical Director or Physician Reviewer will be responsible for all medical necessity denial decisions.

All non-licensed health care professionals may collect data for review, approve services using explicit criteria and may not deny or make decisions that require clinical judgment.

The UM Coordinators work in conjunction with the Medical Director and the UM Committee to oversee the authorization process. The UM Coordinator monitors timeliness and appropriate choice of provider(s) while checking for accuracy of coding and completion of the referral process. The UM Coordinator will follow approved process guidelines for review, authorization, and denial of requested services by the Medical Director and/or the UM Committee. The denial reason in the letter will match the Medical Director's denial rationale documented in the case file. All UM Coordinator activity will be well documented.

The Utilization Management staff will be available at least 8 hours during normal business hours for utilization management related incoming calls from members/providers. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. All employees will identify themselves by name, title, and IPA name for each incoming and outgoing call. If a member contacts the MSO through a collect call process, the Staff member will accept the call to address the member's needs. An UM staff person is available after normal business hours and on weekends for any UM issues. Members with language assistance needs will be connected to interpreters including members with hearing impairment who may choose to utilize 711 or TTD/TTY line for coordination of calls.

All authorization or denial determinations will be based on medical necessity and will reflect appropriate application of the approved medical necessity guidelines in consideration of the hierarchy of criteria.

The UM Manager/Supervisor or UM Lead monitors the timeliness of referral decisions and notifications daily. The Utilization Management Committee will monitor turnaround times for decision making and notification at

their UM Committee meeting at a minimum quarterly. Monitoring reports will include timeliness by type of referral [Non-Behavioral Health Pre-service Standard & Urgent, Urgent Concurrent, and post-service/Retroactive; Behavioral Health pre-service Standard & Urgent, Urgent Concurrent, and post-service/Retroactive; and Pharmacy Referrals Standard, Urgent, post-service Retroactive] for each health plan and each line of business individually. Monitoring reports will include numerator and denominator by type and a compliance percentage.

Time frames will address the best interest of the member and meet all regulatory and contracted health plan mandates for the amount of time allowed to process referral authorization requests. All requests for expedited (urgent) organization determinations must be handled in an expedited manner, without requiring that the request meet "urgent criteria".

A member, member's representative, or any physician (regardless of contract status) may request a referral for services.
Members may make verbal requests for standard organization determinations, except where the request is for payment. The day/time of the request from the member will become the receipt date for processing. If the request was first made to the member's plan, then forwarded to the group from the plan, the group will follow the date/time of the member notification to the plan.

Medicare members may request orally or in writing organization determinations for payment for temporary out-of-area renal dialysis services, emergency services, post stabilization care or urgently needed services when the member believes they are covered by Medicare or when not covered should have been furnished, arranged for or reimbursed.

If action is not taken within 30 calendar days after receipt, on written requests for prior authorization of covered services, the request will be deemed approved. Action includes approval, denial, deferral, modification, reduction, suspension, and termination.

Members will be referred to providers listed on the specialist roster. The specialist roster is a list of all contracted and credentialed providers. In some cases, the PCP may request the assistance of the UM Coordinator in locating a provider within a specific specialty. The UM Coordinator will first check the roster to direct to a contracted provider that can provide the services requested. If the IPA does not have an active contract in place or the location of the specialist office does not meet the members' need or cultural needs, the UM Coordinator will work with Provider Services to locate a specialist. In some cases, the UM Coordinator and Provider Services may contact the health plan for directions to a health plan contracted provider.

Out of network referrals are authorized only when there is compelling medical reason that the services cannot be performed in-network and/or when continuity of care needs are identified or if the member's cultural needs could not be met by contracted provider and will be handled according to health plan policy.

Members may be re-directed to an in-network provider as long as the same medically necessary services can be provided in a reasonable time period and within the member's travel distance.

Tertiary Care Services will be authorized for medically indicated services when a member requires testing or treatment that is otherwise not available at a non-tertiary level of care.

The IPAs may authorize Tertiary Care services under the following circumstances:

1. A member requires testing or treatment that is not otherwise available at a non-Tertiary level of care.
2. A member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated care plan.
3. A member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-tertiary level of care.
4. When a member requires work up at a Center of Excellence; and
5. There are no quality-of-care issues for the Provider.

Whenever a member requires a service for which the group does not have a contracted specialist/facility in place, a one-time letter of agreement (LOA) contract to the non-contracted provider may be obtained through coordination with Provider Services. Once the referral is approved to the non-contracted provider the UM Coordinator will work with Provider Services to ensure timely coordination of one-time contract approval and rates. The LOA process will not affect the Turnaround Time for an Expedited Organization Determination request. Provider Services will ensure verification that the provider/practitioner was not under sanction or excluded at the time the authorization was processed by checking the following sources: State Suspended & Ineligible Website, Office of Inspector General - OIG Website - List of Excluded Individuals/Entities (LEIE) Database, SAM Website - (System for Award Management), Medicare Opt Out reports for Northern and Southern California, Medicare Preclusion List and maintain documentation of the verification, including run dates and name/initials of person running and reviewing the exclusion/sanction reports. When a member is referred to a non-contracted provider and an LOA is not required, the provider will be verified against the State Suspended & Ineligible Website, Office of Inspector General - OIG Website - List of Excluded Individuals/Entities (LEIE) Database, SAM Website - (System for Award Management), Medicare Preclusion List and Medicare Opt Out reports for Northern and Southern California and documentation of the verification, including the run dates and name of person running and reviewing the exclusion/sanction reports, will be maintained with the referral. Services will not be authorized for any ordering/servicing provider listed on the exclusion lists. Medicare members may not be referred to providers who have opted out of Medicare. Written notice of denial must be issued. The only exception is for emergency or urgent services.

For Medicare members requiring carotid artery stenting, certain oncologic PET Scan, Lung Volume reduction surgery, Ventricular assist device [VAD] destination therapy, members will be referred to a Medicare certified facility in referring members. For a list Medicare Certified facilities, the UM Coordinator must check the CMS website at www.cms.gov/MedicareApprovedFacilities/BSF/list.asp to verify prior to approval of the procedure.

For any invasive procedure or treatment, the PCP and/or specialist will be responsible to ensure that an informed consent prior to the procedure being performed.

In the case of human sterilization, the consent form must be completed 30 days prior to the procedure date (per Title 22, Section 51305 (1), (2), (3), (4). Consent must contain the treating physician's signature, the member's signature and date of procedure. The provider's claim must also include a copy of the PM330 Sterilization Consent form in order for payment to be rendered. The form will be reviewed by the Claims Department prior to payment.

See UM/CM/CCR mailroom process for timing of outgoing mail during business week. All correspondence to Medicare members will be sent in a pre-printed envelope marked "Important plan information" in 12-point font on front of envelope. CMS allows for pre-printed labels or ink stamp.

The Primary Care Physician is responsible for ensuring that the member is contacted within one day of approval.
The Primary Care Provider may assist the member in making an appointment for services. The Primary Physician will log the referral and member contact and complete the log process when the Specialist findings report, or Lab X-Ray results are received. The Primary Care Physician is responsible to follow up with the member to ensure the member follows through on all service requests.

The Medical Director may call upon a Board-Certified physician for assistance in determining medical necessity of referral request.

The UM Committee, composed of physicians in active practices, to include Behavioral Health representation when required, will determine guidelines for the referral process. For example: whether all referrals from the PCP to a specialist require authorization or if only follow-up visits and certain specialty referrals need to be authorized.

Speech Therapy service will be reviewed for coverage determination according to the member's health plan in accordance with California Department of Managed Health Care (DHMC), Centers for Medicare and Medicaid and California Department of Health Care Services [DHCS] guidelines.

Specific procedures have been developed for Direct Access to care and to meet regulatory requirements. Otherwise, the verification of eligibility, documentation standards, medical review process, etc. in this policy apply to all types of referral authorizations and addendum policies. For Service excluded from prior authorization, see policy & procedure UM3 Direct Access.

All determinations are followed by notification to the providers and members according to HICE and/or health plan regulatory requirements. Notices will include co-branding as required by the member's health plan. Written notifications to members are mailed. Providers with portal access are notified electronically. Providers without portal access are notified by fax. All denial notifications to providers will be effectuated by fax and mailed timely to members.

Verbal notification does not replace electronic or written notification and will be completed according to HICE and plan regulatory requirements, [i.e., when provided for urgent, the organization may extend the time frame for written notification to 3 calendar days after verbal]. Verbal notification requires communication with a live person and may not leave a voicemail. The time and date of the notification and the staff member who spoke with the practitioner or member is documented in the referral record.

Upon notification of a failed notice to a provider, outreach to the provider will be made the same day via telephone to ensure verbal notification and verification of correct contact information. Copy of the failed attempt, verbal notification and/or completed notification attempt will be maintained with the authorization.

Upon receipt of any returned mailing to a member, the member will be contacted using the phone number on file to notify the member of the returned mail and verify current mailing address. If the phone number on file is also invalid, outreach and verification with the member's PCP will occur. A copy of the returned mail envelope will be attached to the authorization file and new letters will be forwarded to the correct address. Member Services will be notified of the correct address so that this can be coordinated back with the health plan to ensure the address is corrected at the health plan level.

DEFINITIONS:

Authorization:
Approval granted by designated licensed staff in advance of rendering of a service, unless otherwise specifically stated, after appropriate medical, dental, or other review.

Covered Services:
Those services set forth in Title 28 of the California Code of Regulations, which are described in health, plan contracts are medically necessary and are included in the Capitation Rate.

Concurrent Review: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, not prior reviewed.
Criteria:
A Standard or measure by which a decision can be made, a model or test.

Emergency Medical Condition:
A medical condition, which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person 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 the individual in serious jeopardy (or the health of mother and unborn child in the case of a pregnant woman); Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

Emergency Services:
Covered Services furnished by a qualified provider which are needed to evaluate and stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

Expedited Organization Determinations (EODs) for Medicare Members:
A request by a Medicare member, member's representative, or physician to authorize service within 72 hours. An authorization or denial decision AND member notification of the decision must all occur within 72 consecutive hours of receipt of the request. All requests for expedited (fast) organization determinations must be handled in an expedited manner, without requiring that the request meet "urgent criteria".

Geographical Access: 30 miles or 60 minutes from member's home.

Medical Necessity for Medicare Services: Reasonable and necessary services for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body members or otherwise medically necessary under 42 CFR §1395(y).

Medical Necessity for Medi-Cal Services: Reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate server pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code Regulations (CCR) Section 51303.
Organization Determinations for Medicare Members:
A request by a Medicare member, member's representative, or physician for authorization or payment for a health care item or service.

Primary Care Physician or PCP: A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

Pre-Service/Prior Authorization:

Process of obtaining authorization prior to the member receiving non-emergent services. The following criteria must be met before prior authorization can be determined: Member eligibility, benefit coverage, medical necessity, location, and appropriateness of services.

Provider:
A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, or other person or institution that furnishes health care items or services.

Specialist Physician:
A physician whose area of expertise is limited to one area of practice, such as Orthopedics, Ophthalmology, provider does not provide initial and primary care.

Turnaround Times:
The time it takes from receipt to completion of the authorization process.

- Start date: The date and time on which the request is received. If the provider faxes a request or enters an automated system, the start date is the date the fax sent by the provider or entered into the automated system, not the date the UM staff entered into the system.
- End date: The date and time which the decision is made, initial and written notifications to the provider and member as well as includes any turn-around time for extension based on sending timely extension notice.

Timely Member Mailed Notification: This is evidenced on the universe by documenting the date and time the letter was deposited in the courier drop box.

Tertiary Care: highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Urgent Services:
Those covered services that are required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Urgent Pre-Service Request: An urgent request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations, could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, and/or could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, and/or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

PROCEDURE:

A. A member, member's representative, or any physician (regardless of contract status) may request a referral for services. All referral requests are received by phone, by facsimile, or via electronic submission must be immediately entered into the authorization system or must be assigned a manual referral tracking number. The date and time the request was received must be documented in the authorization system.

1. Provider responsibilities when requesting authorizations:

i. Complete the referral authorization form.
ii. Document the request in the member's medical record.
iii. Upon notification of determination, provide follow-up care as appropriate, including monitoring the referral Specialist Physician visit and reports, and updating the medical record to reflect the current treatment plan based upon the Specialist Physician's recommendations.

B. The UM Staff will ensure date-stamps the referral on date received. This initiates the referral process and becomes the referral open date.

C. Member eligibility and benefits are verified.

i. If the service is a benefit of the member's health plan but the group is not delegated review of the service, the request will be forwarded to the health plan and/or coordinated with the appropriate agency immediately upon identification to allow the plan time to process according to timeliness requirements. The PCP office will also be notified and instructed where to send these types of requested on a go forward basis.
ii. The group will issue an "informational letter" when the Member has requested services that the group does not have responsibility for providing or authorizing. The letter will guide the members to their health plan for services, and a copy of the request and records will be forwarded to the health plan.

D. The request is checked for completeness. The authorization must contain the following information:

1. Member Name
2. Health Plan (& other insurance)
3. Member ID/Subscriber #
4. Requesting Provider
5. Referral Provider
6. Services requested, including CPT codes.
7. Diagnosis, including ICD-10 codes.
8. Clinical History, treatment plan, medications, etc.
9. Place of service
10. Estimated length of stay and/or dates of service.

E. Supporting chart notes, specialist or diagnostic findings and previous referral history may also be reviewed. Supporting documents may include but is not limited to, office and hospital records such as evaluations, treatment plans or progress notes from PCPs or Specialists, operative and pathology reports, patient psychosocial history, photographs, a printed copy of criteria related to the request, information regarding benefits for services or procedures, information regarding the local delivery system, and information from responsible family members. When making a determination of coverage based on medical necessity, relevant clinical information is obtained and consults with the treating physician, as necessary.

F. <u>If the authorization information is incomplete</u>, the request is deferred, and the necessary data is obtained.

1. The provider will be contacted within 24 hours to obtain the additional information. The time frame for processing the referral is pended until the appropriate information is available for review. The Staff will ensure:
    a) A minimum of three documented attempts during normal office hours,
    b) Document all requests for information, and maintain that documentation within the case file,
    c) A specific description of the required information
    d) The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact,
    e) The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, e-mail and/or overnight mail with certified return receipt.
    f) Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained by the plan.

G. The Medical Director/Physician Reviewer reviews all referrals except those specifically listed as Direct Access or Self-Referral, daily and documents the criteria utilized in the decision-making process.

H. The Medical Director/Physician Reviewer may also contact a board-certified specialist from the specialty roster for assistance with review determination. His contact with the specialist may be by telephone or face-to-face conference.

I. The Medical Director/Physician Reviewer and UM Coordinators will follow the HICE Timeliness Standards by line of business. Member requests or requests from a representative on behalf of a member will follow the same timeframes as a request from a Provider. Unless the Health Plan requires otherwise or in case of no HICE Standards, the following will be utilized:

1. Routine/Standard Organizational Determination referrals will be processed within 5 working days of receipt, or sooner when in the best interest of the member.

    i. All standard requests for injectables will be processed and completed with notification to the Provider within 72 hours of receipt of the request (or 24 hours for Medi-Cal health plans that apply SSA or W&I code.)

    ii. The UM Coordinator will ensure use of required forms [SB866] for timely processing as per health plan requirements.

2. Urgent/Expedited Organizational Determination will be completed within 72 hours of day/time of request or sooner when in the best interest of the member. [See K Urgent/Expedited Organization Determination below for additional requirements]

    i. In addition, all urgent requests for injectables will be processed and completed with notification to the Provider within 24 hours of receipt of request.

- Failure to respond within the applicable time frame (24 urgent & 72-hour nonurgent), the prior authorization request shall be deemed to have been granted.

ii. The UM Coordinator will ensure use of required forms [SB866] for timely processing as per health plan requirements.

3. Retrospective Determinations will be completed within 30 calendar days.
4. Urgent Concurrent and Hospice Inpatient Care decision will be made within 24 hours of the receipt of the request.

All determinations are followed by notification to the providers and members according to HICE and/or health plan regulatory requirements. Notices will include co-branding as required by the member's health plan.

5. For Integrated Determinations [D-SNP line of business], the standard Medicare or Medi-Cal pre-service requests will be processed within 5 working days of receipt but no later than 14 calendar days, no extensions are allowed. Expedited pre-service requests will be processed within 72 hours, no extensions are allowed. Part B Drug requests are processed within 72 hours for standard and 24 hours for urgent requests; no extensions are allowed.

J. Types of Decisions:

1. Approved / Favorable Determinations:

a. The determination is documented in the system with date and time decision was made.

b. Approved requests will include an authorization number and specific number of treatments indicated. This information will be on the notification to the member and provider.

c. Member and Provider notice of approval determinations may occur orally and/or written to both the member and the requesting provider.

d. Notification to members will be in the health plan/regulatory approved templates, furnished by the health plan in threshold languages, and will include LAP notice to the member on how to request translation services and alternative format where needed.

e. Notification to the member will be given in a manner that is easily understood by the member. When documentation shows the member is limited English proficient, all attempts will be made to notify member in their primary language.

2. Delay/Deferrals/Pending Determinations:

a. Referrals may be placed in a pending status in the system due to needs for additional information/testing, requires consultation with an expert reviewer, benefit determination and or coordination of benefits.

i. Medicare standard referral requests will not be delayed/deferred - All decisions will be made within 14 calendar days or sooner in the best interest of the member.

ii. For Medicare Expedited requests, an extension of time may be allowed for only out-of-network providers, if the enrollee requests the extension, or the Medical Director/Physician Reviewer can justify to a Health Plan or regulatory body [DHCS and/or CMS] reason for extension meets all the following:
    - The extension is in the Enrollee's interest; and
    - There is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
    - The outstanding information is reasonably expected to be received within fourteen (14) calendar days.

b. The Provider will be contacted on the same day via telephone with the reason for delay.

c. Incomplete referrals, or where additional information is needed for determination, may be Pended for 5 days. However, if the member's condition dictates an urgent response due to any imminent and serious threat to the health of the member, a decision will be made within 72 hours. The notice to the Provider and Member will list the timeframe for submitting requested information.

d. If the referral decision is delayed for additional services to be performed (ie. Lab Test, X-ray, etc.) and the service does not occur within the 5 days, the referral can be extended to a total number of 14 days for Medi-Cal and up to 45 days for Commercial, from the original date of receipt. In some cases, the Medical Director may choose to Modify the referral, pending the results of testing, which then closes that referral request.

e. The UM Coordinator must ensure the information needed to make a determination of medical necessity has been collected. Collection of information must not be overly burdensome for the member, the practitioner or staff.

f. The member and the provider must both be notified in writing with reason for delay and expected date of decision to be made. The reasons for delay may include, but are not limited to, information was requested but not received listing specific information needed, consultation by an expert reviewer is required and list specialty of expert, and additional examination or test is needed prior to final decision, listing exact services/testing required. Benefit or contractual clarifications are not appropriate reasons to delay a request.

g. For Commercial, once all information is received the Medical Director must make his final decisions within 5 days.

h. All Pended referrals are tracked by the UM Coordinator to ensure timeliness of completion. A system log of all Pending referral activity is monitored and can be run at any time.

3. For Denial Determinations: (See UM11 Service Denial Process) All service denials will be documented in the system and processed according to health plan and regulatory requirements for timely and appropriate notice of denial to provider and member. Denial notifications include reason for denial and suggested alternative treatment and notice to member will contain easily understandable language. Attempts will be made to send the denial notification in the member's primary language. Providers will be given information on how to contact the Medical Director/Physician review to discuss the denial reason. Member notification will include appeal rights, and availability of criteria upon request as appropriate. When issuing a denial of an integrated organization determination, the IPA will use an integrated notice when notifying the member of the determination.

4. Modified/Partially Favorable Determinations: If the determination is to approve a portion of a requested service and modify the other portion of the requested service (partially favorable):

    a. For Commercial: Initial notification to the Provider will occur either oral or written within 24 hours of modification. Written notification to the member will be sent within 2 business days of the decision and in health plan/regulatory approved letter template. Members' rights to appeal a decision will be included along with LAP notice.

    b. For Medicare: Notification to the provider will occur within 24 hours in writing. Written notification to the member will be sent concurrently utilizing the approved health plan/regulatory NDMC template for notice of the denied service and the approved health plan/regulatory approval notice for the approved portion. Members' rights to appeal a decision will be included along with LAP notice.

    c. For Medi-Cal: Notification to the provider will occur within 24 hours in oral or written communication. Written notification to the member will be sent within 2 business days of the decision utilizing the approved health plan/regulatory "modification" notice. Members' rights to appeal the decision will be included and where required a LAP notice will also be sent.

K. Process for Urgent Requests / Expedited Organization Determinations (EODs):

1. A member, member's representative, or any physician (regardless of contract status) may request an expedited referral for services for the following reasons:

    a. The member or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy; and/or
    b. The member believes that the health plan or its delegated medical group should furnish directly or arrange for services to be provided (when the member has not *already* received the services outside the contracting network.

2. All expedited requests received by phone, by facsimile, or via secure electronic submission must be immediately entered into the authorization system or must be assigned a manual referral tracking number. The date and time the request was received must be documented in the authorization system.

3. The UM Coordinator immediately forwards the expedited request to the Medical Director or UM Physician Reviewer for a decision.

    a. Medical Director/Physician Review determines request does not meet criteria for expedited decision:

        i. The request may be transferred from an expedited to a standard request. Oral notification must be made to the member within 72 hours of the receipt of the request. Documentation of the notice to the member or designated member representative will include the name, date and time of notification and name of coordinators name/title. For Medicare where required, the oral notification is followed by a written health plan/regulatory approved notification "Expedited Criteria Not Met". This notice will inform the member and/or their designated representative of their right to file an expedited grievance, right to resubmit request for expedited determination and instructions/time requirements for filing the expedited grievance process.

    b. If the Medical Director/Physician Reviewer determines that an extension of time is needed to determine status, an extension of time shall be allowed if:

        i. The Enrollee or the provider requests an extension; or

        ii. The Medical Director/Physician Reviewer can justify to a Health Plan or regulatory body [DHCS and/or CMS] reason for extension upon request meets all the following:
            - The extension is in the Enrollee's interest; and
            - There is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
            - The outstanding information is reasonably expected to be received within fourteen (14) calendar days.

        iii. Providers and Members will be notified within 72 hours within the receipt of the requests orally of the decision for an extension of time. The reason for the delay will be explained as well as the members' right to file an expedited appeal. The oral notification will be followed by a written notice [MA-Extension] within 72 hours of the receipt of the requests. The letter will also include the delay reason and the process to file an expedited appeal.

        iv. Upon receipt of all information, the Medical Director/Physician Reviewer will make a final determination of approved or denied. [See 3 a. or 3 c.]

    c. Medical Director/Physician Review determines the request meets criteria for expedited decision, the decision is made, and the following occurs:

i. Oral notification to the enrollee and the physician involved will occur as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. Notification to the enrollee will occur orally and in writing, with oral and/or written notification received within the 72-hour time frame.

a). If the request is approved, the member will be given the authorization number and information on how to contact the approved provider.

b). If the request is denied, the member will be given the specific reason for the denial, and their appeal rights. The member will also receive the approved health plan/regulatory written notification by mail "NDMC" or "IDN" within 72 hours of initial receipt of the expedited request not to exceed 3 days from oral notification.

ii. If a member cannot be reached upon first call, a total of 3 attempts will be made to reach the member and the written notice will be mailed via certified mail return receipt requested. The letter must evidence that it was mailed within 72 hours from the date/time request was received or sooner. Documentation evidencing the mailing will include the initial request date/time and the notification date/time and will be maintained in the system.

4. A file for each expedited request will be maintained in the system and include, but is not limited to the following:

   a. Documentation or evidence of the date and time the initial request was received.

   b. Documentation of the service(s) requested.

   c. Supporting documentation (all medical records or other pertinent information available must be considered to ensure appropriate and timely resolution and determination for members.

   d. Evidence of the determination and the date and time the determination was made by a physician reviewer or designee.

   e. Documentation or evidence of the date and time of verbal communication to the member, or member's representative, and provider as appropriate.

   f. Evidence or written communication and date and time of the written communication to the member, or member's representative, and provider.

5. Daily monitoring to ensure timeliness of expedited requests will occur by Supervisor and be reported to the health plans monthly.

L. If a referral is redirected to an in-network provider, the UM Coordinator will contact the in-network provider to ensure that the in-network provider is available to accept new members, can provide the same service covered by the member's benefit plan, the distance from the member's home and will document with date, time and person who confirmed this information.

M. The Medical Director and Utilization Management Committee review complex cases and determinations for denial of requests. (See Denial policy for further clarification of denial process).

N. On a daily/weekly/monthly basis a report of all referral activity including any open or pending referrals is run to ensure compliance with timeliness of the referral process and notifications. The UM Committee will review compliance with timeliness and notifications as part of their quarterly UM Work Plan by plan, type of referral and line of business.

O. On a monthly basis all unused referrals (no claims paid report) will be run and sent to PCPs to follow up with the members.

FORMS:
Referral Authorization Worksheet
Utilization Management Timeliness Standards – Medi-Cal, Medicare, Commercial – HICE
Prescription Drug Prior Authorization or Step Therapy Exception Request Form – SB688

REFERENCES:
Title 28, California Code of Regulations
CA Health and Safety Code 1367.01 (a), (h) 1-5 and 1370.4 (c) (1)
Policy and Procedure UM11 – Service Denial Process
Policy and Procedure UM3 – Direct Access
Policy and Procedure UM5 – Emergency and Urgently Needed Services
NCQA: UM3, UM4 and UM 5
HICE Utilization Management Timeliness Standards
Social Security Act, §1927(d)(5)(A)
W&I Code, §14185(a)(1)

SUBJECT: Medical Review Criteria **Policy #:** UM2
DEPARTMENT: Utilization Management

Effective Date: April 5, 1997
Last Revision Date: December 20th, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define how IPA will select, review, approve and utilize written criteria for making Utilization Management decisions.

POLICY:

Criteria and guidelines used in making utilization review decisions shall be:

- Developed with involvement from actively practicing health care providers.
- Applied in consideration of the local delivery system.
- Consistent with accepted standards of practice.
- Objective and based on medical evidence.
- Available to all providers, staff, and members upon written request.

Utilization criteria will be reviewed and updated annually. The updates will be utilized by all departments (i.e., Utilization, Quality, Member Services, Claims, etc.) including the IPA. The QMC is responsible for distributing updates and revisions to the providers and practitioners.

The Utilization Management Committee will use the following hierarchy of criteria resources:

1. Member eligibility and benefits will be verified prior to applying criteria.

2. Federal or State Guidelines, where applicable, the following hierarchy will be followed:

    - <u>For Medicare/Medicare Advantage</u>:
      CMS is Primary Source with hierarchy:
        - National Coverage Determinations [NCD]
        - Local Coverage Determinations [LCD],
        - Local Coverage Articles [LCA],
        - Medicare Manuals [Medicare Managed Care, Medicare Benefit Policy, Medicare Program Integrity, Medicare Claims Processing]

            - For Part B Drug and Biologicals Only: Use Medicare Approved Drug Compendia and/or relevant guidance from the FDA according to the rules in the Medicare Benefit Policy Manual Chapter 15,

Section 50.4, and sub-chapters, paying special attention to the distinctions for anti-cancer chemotherapy regimen drugs (50.4.5) and immunosuppressive drugs (50.5.1)

- For Medi-Cal: DHCS criteria is primary source
    - Pharmaceuticals covered under medical or pharmacy benefits.
        - [Pharmacy benefits, other than those covered by the medical benefit will be coordinated with the member's health plan]
        - Authoritative Compendia
        - Medi-Cal Approved Compendia pursuant to SSA 1927 (g)(1)(B) and(k)(6).
- For Commercial: DMHC - Knox Keene Act - Title 28 is the Primary Source
- World Professional Association for Transgender Health [WPATH]: Standards of Care for the Health of Transsexual, Transgender and Gender nonconforming people from WPATH will be utilized as primary source to provide clinical guidance in determination of coverage.

3. Health Plan specific criteria
4. Evidenced based criteria: Apollo Medical Review Criteria Guidelines for Managed Care
5. Community Medical Standards per availability as appropriate by health plan and line of business: American Medical Association; American Academy of Pediatrics; American Board of Obstetrics and Gynecology; American Board of Internal Medicine/Family Practice, Hayes, UpToDate, InterQual, MCG, National Comprehensive Cancer Network Guidelines, Agency for HealthCare Research and Quality, Cochrane Review.
6. Practice Guidelines developed by the Quality Management Committee in conjunction with the UMC.

If the group uses internal guidelines/criteria when making medical necessity determinations that guideline/criteria will be accessible to the public and include the following information.

1. The internal coverage criteria in use and a summary of evidence that was considered during the development of the internal coverage criteria used to make medical necessity determinations.
2. A list of the sources of such evidence; and
3. An explanation of the rationale that supports the adoption of the coverage criteria used to make a medical necessity determination.

Apollo Care guidelines does not replace, modify, or supersede existing Medicare Regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). These supplemental medical necessity criteria are based upon evidence-based guidelines and clinical studies in the peer-reviewed published medical literature. Apollo Care guidelines an evidence-based criteria are used when medical necessity criteria for a service have not been fully established by the Centers for Medicare and Medicaid Services (CMS) to prevent delays in care when making medical necessity determinations. HealthSmart Management Services Organization, Inc., believes the benefits of using Apollo Care Guidelines reduces the risk of delays in care or access to items or services by providing timely medical necessity determinations which ensures patients receive services that are appropriate, safe, and effective, which outweigh any clinical harms.

Internal coverage guidelines/criteria may only be used to confirm the presence of diagnosis or other medical criteria and/or to ensure that an item or service is medically necessary.

When the IPA is making a coverage determination on a Medicare covered item or service with fully established coverage criteria, the IPA cannot deny coverage of the item or service based on internal, proprietary, or external clinical criteria that are not found in traditional coverage policies.

For the D-SNP activity, where there is an overlap between Medicare and Medicaid benefits the group will apply the definition of medical necessity that is the more generous.

The IPA will consider both Medicare and Medicaid coverage criteria and make a determination as to a full or partial denial of an integrated organization determination.

Where delegated pharmacy medical decision review, a physician will review for medical necessity prior authorization requests for pharmacy requests requiring step therapy.

The clinical criteria will be the current version and no more than 2 years old. The Board of Directors delegates to the QMC the approval of the criteria. This will include UM Staff, UMC active practice & board-certified physicians, to include Behavioral Health, and appropriate subspecialties where necessary.

Medical Review Criteria will be reviewed and updated at least annually.

Dissemination of criteria to contracted providers will be accomplished as described in the policy entitled: Correspondence/Dissemination of Information.

Criteria will be made available to all providers, members, and public upon any written or verbal request. The information will be provided in a timely manner either via fax or mailing.

Disclosure is only required for specific procedures or conditions requested. IPA may charge a reasonable cost for copying and postage for the requested information. The following will be included on all written criteria or guidelines sent:

> "The materials provided to you are guidelines used by this IPA to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Per DHCS APL 17-006, Medi-Cal beneficiaries may request, free of charge, copies of all documents and records relevant to the NOA [Notice of Action/ Notice of Adverse Benefit Determination], including criteria or guidelines used.

The IPA will not specifically reward Providers, or any other individual involved in the UM decision making process for issuing denials of service or encourage decisions that result in underutilization of services. All persons involved in the UM decision making process will sign a statement stating they agree to ensure that all decisions will be made based upon medical necessity and appropriateness of care. This statement will be signed and updated on a yearly basis and notification to all providers of this agreement will be distributed.

For management of members with Chronic Hepatitis C, the group will follow the Treatment Policy for the Management of Chronic Hepatitis C developed by the Department of Health Care Services, effective July 2018 which is located at http://www.dhcs.ca.gov/Pages/HepaitisC.aspx .

DEFINITIONS:

Assessment of Local Delivery System**:** Local delivery system considerations include:

- Availability of inpatient outpatient and transitional facilities; availability of outpatient services in lieu of inpatient services such as surgery centers vs. inpatient surgery.
- Availability of highly specialized services, such as transplant facilities or cancer centers.
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge.
- Local hospitals' ability to provide all recommended services within the estimated length of stay.

MEDICAL NECESSITY - General: Services reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary.

Medical Necessity for Medicare Services: Reasonable and necessary services for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body members or otherwise medically necessary under 42 CFR §1395(y).

Medical Necessity for Medi-Cal Services: Reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate server pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code Regulations (CCR) Section 51303. Medi-Cal Compendia pursuant to SSA 1927(g)(1)(B) and (k)(6)

Medical Necessity (Commercial): Health care services provided to a member, exercising prudent clinical judgment, for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, that is (a) in accordance with generally accepted standards or medical practice; (b) and clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the member, physician or health care provider, and not more costly than an alternate service or sequence of service at least as likely to produce equivalent therapeutic or diagnostic results as the diagnosis or treatment of the member's illness, injury or disease.

Medical Necessity defined by NCQA: NCQA defines medical necessity review as a process to consider whether services that are covered only when medical necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies.

NCQA's UM Standards specify the steps in the medical necessity review. [see Clinical Criteria]. Medical necessity review requires that denial decision be made by an appropriate clinical professional. The Medical Director and Physician Reviewer are responsible for all denial decisions.

NCQA defines decisions about the following require medical necessity review:

- Any covered medical benefits defined by the Certificate of Coverage or Summary of Benefits, including

but not limited to:

- Dental and vision services covered under medical benefits, including dental care or services associated with procedures with procedures that occur within or adjacent to the oral cavity or sinuses.
  - If medical and dental benefits are not differentiated in the benefits plan, the organization includes request for care or services associated with denial procedures that occur within or adjacent to the oral cavity or sinuses for medical necessity review.
    - [Dental coverage not medical in nature will be coordinated with the member's health plan for review and determination].

- Pharmaceuticals covered under medical or pharmacy benefits.
  - [Pharmacy benefits, other than those covered by the medical benefit will be coordinated with the member's health plan]
  - Authoritative Compendia
  - Medi-Cal Approved Compendia pursuant to SSA 1927 (g)(1)(B) and(k)(6).

- Preexisting conditions when the organization has a policy to deny coverage for care or services related to pre-existing conditions. [In the State of California, there are no pre-existing conditions. Continuity of Care rules apply.]
- Care or services whose coverage depends upon specific circumstances.
- Out of network services that are only covered in clinically appropriate situations.
- Prior authorization for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
  - [Pharmacy benefits, other than those covered by the medical benefit will be coordinated with the member's health plan]
- Experimental or investigational requests covered by the organization.
  - [Upon identification of any service deemed experimental or investigational, the request will be immediately, within one business day, directed to the member's health plan for review].

NCQA defines decisions about the following do not require medical necessity review:

- Services in member's plan that are limited by number, duration, or frequency.
- Extensions of treatments beyond the specific limitations and restrictions imposed by the member's plan.
- Care or services whose coverage does not depend upon specific circumstances.
- Request for personal care services, such as cooking, grooming, transportation, cleaning, and assistance with other activities of daily living [ADLs].
  - [These services if covered by the members plan, but not delegated to the group, request is coordinated with the health plan.]
- Experimental or investigational requests that are always excluded and never covered under any circumstance.
  - [Upon identification of any service deemed experimental or investigational, the request will be immediately, within one business day, directed to the member's health plan for review].

PROCEDURE:

A. Member eligibility and benefits will be verified prior to applying criteria. Then hierarchy for criteria will be followed.

B. The uniqueness of the case will be taken into consideration when attempting to apply criteria. The criteria will be based on the needs of the individual in consideration of age, co-morbidities, complications, home environment, progress of treatment and psychosocial needs.

C. The IPA will consider both Medicare and Medicaid coverage criteria as appropriate by Line of Business and make a determination as to a full or partial denial of an integrated organization determination.

D. The minimum information required includes:
   1. Medical necessity
   2. Estimated length of stay
   3. Intensity of services & severity of illness
   4. Appropriate level of care
   5. Service area

D. Review criteria will be applied consistently to all requests to ensure Inter-Rater Reliability.

E. When review determinations do not meet established criteria, the request will be referred to the Medical Director or the UMC.

F. When the case is considered for approval, modification, or denial and outside the merits of the established clinical criteria, the Medical Director/Physician Reviewer may seek a second opinion. This decision for second opinion will be clearly documented.

G. Consideration will also be given to including availability of hospitals to provide services or SNF, sub-acute or home case services as dictated by members' benefit coverage.

H. The review determination source (clinical criteria) will be made available to providers and members who make a request.

I. The review determination will be documented on every member and provider letter that modifies or denies care. Along with the alternative treatment, the clinical criteria supporting the decision will be written in layperson language.

FORMS:

None required.

REFERENCES:

California Health and Safety Code, Section 1363.5
P&P QM 7 - Correspondence/Dissemination of Information
NCQA UM 2 Clinical Criteria for UM Decisions
42 CFR § 422.101 (b)(6)(ii)-Internal Coverage Policies (Clinical Criteria)

SUBJECT: Specialty Care Referrals – Standing and Extended Access **Policy #:** UM6
DEPARTMENT: Utilization Management

Effective Date: January 1, 1999
Last Revision Date: July 5, 2022
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To support the provision of standing referrals for members with chronic conditions requiring ongoing specialty care. [i]

To provide for educational needs of the medical group's Primary Care and Specialty Care Physicians regarding AB 1181, and the internal policies and procedures in place to ensure compliance with this legislation.

To design the framework for the Primary Care Physician to request a Standing or Extended Access referral to a specialist.

POLICY

PRACTICE GUIDELINES: The Primary Care Physicians and Specialists will be provided with a listing of conditions that may qualify for approval. The Guidelines will indicate the number of visits and time frame that the condition may cover. The duration of a standing referral for members requiring continuing specialty care over a prolonged period of time must be more than 1 visit.

The Credentialing Department is responsible for maintaining the roster of all contracted and credentialed providers. The roster will also list any provider meeting all requirements to be listed as an HIV Specialist. Annually, the Credentialing Department will provide a list of all verified HIV Specialists.

DEFINITION:

Specialty Care Physician (SCP) – The SCP will be certified and/or have expertise in the member's disabling condition and be designated to serve as the coordinator of a member's care except for the minor problems unrelated to the major specialty directed condition. HIV/AIDS specialists must meet California health and Safety Code criteria [CA Health & Safety Code 1374.16(g)].

Specialist Standing Referral – A referral to a SCP for a member requiring continuing specialty care for treatment of life threatening, degenerative, or disabling condition over a prolonged period of time, [more than 1 visit], as indicated in the treatment plan, without requiring the PCP to submit for each visit.

Specialist Extended Access – A referral to a SCP for a member who has a life threatening, degenerative, or disabling condition that requires the coordination of primary care services by a SCP.

HIV/AIDS Specialist - A physician who holds a valid, unrevoked, and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:

1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
    A. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
    B. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
4. Meets the following qualifications:
    A. In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
    B. Has completed any of the following:
        1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
        2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
        3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

Life Threatening, Degenerative or Disabling Condition – Terminal Cancers, Acute Leukemia, AIDS, several and progressive neurological conditions, Renal Failure, CHF, and COPD are examples. Other conditions may be described in the "Case Management Program and Screening Criteria".

PROCEDURE:

A. A request for a standing referral will be addressed by either the referral process or through a review of the treatment plan.

B. All time frames to meet referral turnaround time standards will meet the Referral Authorization Process policy (see UM 4) in accordance with the Utilization Management Plan. Decisions and

notifications must be made within the time frames appropriate to the condition of the member (e.g., urgent, non-urgent, concurrent), not to exceed 3 working days of the date that all necessary information is received.

C. The request is submitted by the Primary Care Physician, the Specialist and in some cases at the request of the member (standing referral only) to the Utilization Department.

D. All information as stated in the Referral Authorization Process policy will be required for Specialty Care Referrals, Standing or Extended referrals. Additional information required for consideration includes:

1. Life threatening, degenerative, or disabling conditions, including HIV.
2. The number and frequency of visits and time period requested.
3. The services and treatment to be managed by the Specialists and Primary Care Physician.
4. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, the Provider Group must refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria. A list of appropriately qualified HIV/AIDS specialists is listed on the IPA roster and is updated at a minimum annually by the Credentialing Department.

E. The request is reviewed for medical necessity by the Medical Director, Physician Reviewer or UM Committee within 3 working days of receipt of all information necessary for determination to be made.

F. The request determination is communicated to the member, Primary Care Physician and Provider within one (1) working day. The authorization will include the terms and conditions of the referral, including:

1. The number of approved visits.
2. Time period for which the services are authorized. [Not to exceed one year at a time].
3. The process to request extension.
4. Standard reporting required from the Specialist to the Primary Care Physician, Medical Director and/or Utilization Management Department.
5. If denied, process to request an appeal.

G. After receiving standing referral approval, the specialist is authorized to provide health care services that are within the specialist's area of expertise and training to the member. The PCP shall retain responsibility for basic case management/coordination of care unless a specific arrangement is mutually agreed upon to transfer care to the specialist for a specified period of time.

H. If the request is authorized, the actual referral must be made within 4 working days of the date the request and the proposed treatment plan, if any, is submitted to the designated physician reviewer (e.g., Medical Director).

I. The group is not required to refer members to an out-of-network provider unless an appropriate specialty care provider is not available in the group’s network or the plan.

J. All approved Specialty Care Referral or Standing and Extended Access will be reported to the Case manager. The nurse will open a case management file and follow the Case management policy for care, coordination, documentation, and tracking.

K. The Specialty Care Provider will be required by contract to provide information to the Primary Care Physician, Medical Director and/or Utilization Management Department on the progress and significant changes in the member's condition. All correspondence will be documented in the member's medical record.

L. The UM Department will track all requests for Standing and Extended Access referrals. The status of each case will be reported to the UM Committee and health plans monthly.

FORMS:

Referral Authorization Worksheet

REFERENCES:

California Health and Safety Code, Section 3,1373.96
California Health and Safety Code, Section 3,1374.16
NCQA UM 4.1.7.2.

[i] To meet AB1181, effective 1/1/99 and Section 1354.16 of the Health and Safety Code and Section 14450.5 of the Welfare and Institutional Code. The law requires health plans to establish specific procedures that meet specific standards for ongoing referrals.

SUBJECT: Reconstructive Surgery **Policy #:** UM7
[Formerly named "Prior Authorization - Mastectomy"]
DEPARTMENT: Utilization Management

Effective Date: January 1, 1999
Last Revision Date: September 19, 2019
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure reconstructive surgery will be covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or create a normal appearance (to the extent possible) for members.

To comply with the Breast Cancer Patient Protection Act of 1998[i] which allows the hospital length of stay following mastectomies and lymph node dissections.

To ensure that the providers, staff (including dual risk hospitals) are aware of and comply with the new coverage and utilization requirements.[ii]

To ensure reconstructive procedures will now include surgery for gender incongruent features as defined by the patient because they are considered *developmental abnormalities* when there is a diagnosis of gender dysphoria. According to *Health and Safety Code § 1367.63(c)(1)*, reconstructive surgery means "surgery performed to corrector repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) To improve function. (B) To create a normal appearance to the extent possible."

POLICY:

For commercial members, the IPA will review through the UM process all requests for reconstructive surgery and evaluate if services are reconstructive or cosmetic. All reconstructive cases resulting from congenital defects, developmental abnormalities, trauma, infection, tumors, or disease which may result in improved function will be considered for approval.

The IPA will abide by the following legislative requirements of the Breast Cancer Patient Protection Act:

a) This Act mandates benefit coverage of surgical care and treatment related to a mastectomy or lymph node dissection. This includes prosthetic devices, reconstructive surgery and surgical complications including lymphedema.
b) This Act mandates coverage for prosthetic devices and reconstructive surgery for the breast affected and if, in the opinion of the attending physicians and surgeon, surgery for the healthy breast if necessary to achieve a normal symmetrical appearance.

c) This Act allows the attending physician, in accordance with accepted medical practice and in consultation with the patient, to determine the length of hospital stay without prior authorization.
d) This Act mandates that the providers are not offered incentives to limit or deny care in accordance with the regulatory requirements.[iii]

All requests for elective services including but not limited to, specialty consultations and treatments, surgical procedures, labs, x-rays, and imaging related to breast cancer will be processed according to the Utilization Management Referral policy.

The Utilization Management Department and Case Manager will adopt the following guidelines as an exception to the prior authorization procedures established for hospital admission review.

PROCEDURE:

1. Criteria for reconstruction will be reviewed.
    a. For Transgender services, see http://www.wpath.org/publications_standards.com
    b. For Mastectomies, prior to scheduling a surgical procedure associated with mastectomy or lymph node dissection, determination of medical necessity will be made by the Medical Director, Physician Reviewer or Utilization Management Committee using the appropriate hierarchy of criteria.

2. The UM Department will input the approved authorization along with an estimated length of hospital stay as established by the attending physician. The case will be referred to Case Management.

3. The Case Manager will conduct concurrent review for intensity of service and severity of illness and plan for patient's discharge needs.

4. The actual length of hospital stay is determined by the attending physician in consultation with the patient and will not be pre-established or limited by the authorization process.

5. The Utilization Management Committee may conduct a retrospective review for medical necessity of all services not prior authorized or that are provided under the Direct Access policy.

6. As in any case, any potential quality issues will be referred to Quality Management for review and action. The UM Committee shall ensure that the physician.

FORMS:
Not applicable

REFERENCES:
Women's Health and Cancer Rights Act (WHCRA)

[i] Breast Cancer Patient Protection Act of 1998 AB7 – (Brown), Chapter 787, California Health, and Safety Code Section 1367.635.
[ii] Health Plan is required to update the explanation of coverage (EOC) by 7/1/99.
[iii] NCQA UM 11.3, Provider Incentives SB 750, 1/1/99.
APL 16-013

SUBJECT: Direct Access **Policy #:** UM3
DEPARTMENT: Utilization Management

Effective Date: June 25, 1999
Last Revision Date: December 24th 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To outline the types of services a member can access without prior authorization. These services are those that the provider can authorize for the member as approved by the UMC through health plan policy or by legislation as direct access or as a member self-referral.

DEFINITIONS:

Direct Access: The scope of services for which the provider may directly refer a member without prior authorization. These services must follow the approved utilization guidelines. (See Direct Referral Authorization Indications).

Pediatric Asthma Care: Equipment and supplies medically necessary for the management and treatment of pediatric asthma (AB 2186).

Self-referred services: Direct access services that a member can obtain without authorization from a provider. "Sensitive services" are covered under member Self-referral.

Sensitive services: Family Planning, HIV Testing & counseling, STD testing and treatment, Termination of Pregnancy. These services are the financial responsibility of the IPA as defined by DHS.

Cervical Cancer Screening: any FDA-approved cervical cancer screening test (per SB1219).

Women's Health Specialist: Women's health specialists include, but are not limited to, gynecologists or certified nurse midwives.

LHD-Local Health Department

ACIP- Advisory Committee on Immunization Practices

POLICY:

In consideration of Department of Managed Healthcare and Centers for Medicare and Medicaid regulatory requirements, each group shall establish services that are covered under the Direct Access process. Group may elect additional specific services to add to the standard regulatory requirements for Direct Access.

Direct Access – The IPA shall allow the primary care physician to refer members directly without prior authorization for these services. The Primary Care Physicians will fill out the Direct Access Referral form when sending a member for a Direct Access service. The Primary Care Physician's office will be responsible for applying indication for service and verification of member eligibility. The Primary Care Physicians office will fax a copy of the Direct Access Form to the UM Department and keep a copy in the member's file. Notification to UM Department must be made for retrospective review and claims payment.

Family Planning Services – In this policy Family Planning Services include health education and counseling necessary to make informed choices and understand contraceptive methods, Limited history and physical exam by Family Planning provider, Lab tests if medically indicated as part of decision-making process to choose a contraceptive method, Follow-up care for complications related to contraceptive methods issued by the family planning practitioner, Provision of contraceptive pills, devices, and suppliers, Tubal Litigation, Vasectomies, Pregnancy and Counseling.

Pediatric Asthma Care – The following equipment and supplies are covered when medically necessary for the management and treatment of pediatric asthma: inhaler spacers, nebulizers (including face masks & tubing), and peak flow meters. The IPA shall allow the primary care physician to refer members directly without prior authorization for these supplies and equipment.

Immunizations- Providers must ensure timely provision of immunizations to Member's in accordance with the most recent schedule and recommendations published by ACIP, regardless of a Member's age, sex, or medical condition, including pregnancy. Providers must document each Member's need for ACIP-recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters; illness, care management, or follow-up appointments, Initial Health appointments, Pharmacy services, Prenatal and postpartum care, Pre-travel visits, sports, school, or work physicals, visits to an LHD, and Well patient checkups. As ACIP-recommended immunizations are viewed as preventative services and must not be subject to Prior Authorization.

Cervical Cancer Screening - An annual Cervical Cancer Screening test shall include the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration, upon the referral of the member's health care provider, (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care to the member and operating within the scope of practice otherwise permitted for the licensee). The IPA shall allow direct self referral access when the member, in addition to the conventional Pap test, requests a human papillomavirus screening test (HPV) that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

Self Referral – The IPA shall provide all members the option to seek the following types of services without authorization from their Primary Care Physician or UM:

OB/GYN Services[i]

All services must be medically necessary, covered by the benefits of the health plan and the provider must not be excluded from government programs.

OB/GYN Services covered by this policy include:

- Routine pelvic exam and "cervical cancer screening", Wet Mounts
- Contraceptive counseling and management
- Diagnosis, lab testing and treatment for vaginitis and sexually transmitted diseases
- Chlamydia screening – Providers will ensure that all female members less than 21 years of age who have been determined to be sexually active shall be screened for chlamydia. Follow up of positive results must be documented in the members record. Reasonable attempts shall be made to contact the appropriate identified members and screen for Chlamydia. All attempts shall be documented. If a member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's Medical Record.
- Diagnosis irregular vaginal bleeding
- Diagnosis and treatment of endometriosis with hormone therapy
- Manage premenstrual syndrome with non-steroidal
- Anti-inflammatory hormones and symptomatic treatment
- Evaluate lower abdominal pain to distinguish gynecological from gastrointestinal causes
- Obstetrical Care - Normal pregnancy (to paneled physicians) – Hospital admission maternity benefit will be 72 hours for normal vaginal delivery and 96 hours for normal C-Section.
- Effective March 2, 2016, members will have access to and may self-refer to a contracted Certified Nurse Midwife or Licensed Midwife licensed by the Medical Board of California and/or Freestanding Birth Center who may perform obstetrical services without the supervision of a licensed physician or surgeon. Services provided may include maternity, birth and well-woman care for low-risk women without serious pre-exisiting medical or behavioral conditions. Well-baby care may also be performed up to age 6 weeks post-partum. These services are covered when provided

in private offices, physician offices, clinics, client homes, maternity homes, birth centers and hospitals.

Both CNMs and LMs provide prenatal, intrapartum, and postpartum care including family planning for the mother and immediate care for the newborn. However, CMS are permitted to attend cases of normal childbirth whereas the LMs are permitted to attend cases of normal pregnancy and childbirth and must adhere to a detailed set of restrictions and requirements when a member's condition deviates from the legal definition of normal.

Members will also have access to Alternate Birth Centers and Freestanding Birth Centers for prenatal labor and delivery or postpartum care. Alternate Birth Centers and Freestanding Birth Center is a health facility that is not a hospital where childbirth is planned to occur away from the pregnant women's residence, that is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included and complies with such requirements relating to the health and safety of individuals furnished services by the facility. Freestanding Birth Centers are both a service and a setting for services.

Primary Care Physicians can assist Medi-Cal members in obtaining Certified Nurse Midwife [CNM] or Licensed Midwife [LM] services by accessing the California Association of Midwives website at www.californiamidwives.org. The PCP is responsible for forwarding medical records to the Licensed Midwife within 30 days after receiving the member's request. The member may be referred to a non-contracted provider through the standard referral process. A one-time contract will be put in place as long as the provider is willing to accept a one-time contract. If the provider refuses to contract, the member will be offered an in-network provider option.

- Per DHCS APL 22-010, effective July 2022, biomarker testing will not require an authorization for members with advanced or metastatic stage 3 or 4 cancer or for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer. Authorization will be required only for biomarker-testing that is not for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer.

Sensitive Services[ii]

Members must have access to the following services through self-referral: Family Planning, HIV Testing & counseling, Sexually Transmitted Diseases, Termination of Pregnancy, Sexual Assault and Preventive Services. In addition, members may self refer for pregnancy services to contracted OB providers.

Self Referrals for Mental Health and/or Drug & Alcohol Treatment are dependent upon the member's health plan coverage.

The IPA will pay all self-referrals for sensitive services, including services received without a referral or prior authorization and/or performed by a non-participating provider.

If hospitalization is required in performing a termination of pregnancy service or other treatment of sensitive services, prior coordination for plan authorization/coverage of benefit may be required.

HIV testing & counseling, STD treatment and Family planning do not require members to access providers within the network. Termination of pregnancy requires access within the contracted provider panel when hospitalization is required.

Members may access out-of-plan STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode.
For community providers other than LHD and family planning providers, out-of-plan services are limited to one office visit per disease episode for the purposes of:

- diagnosis and treatment of vaginal discharge and urethral discharge,
- those STDs that are amenable to immediate diagnosis and treatment, and this includes Syphilis, Gonorrhea, Chlamydia, Herpes Simplex, Chancroid, Trichomoniasis, Human Papilloma Virus, Non-Gonococcal Urethritis, Lymphogranuloma Venereum and Granuloma Inguinale and
- evaluation and treatment of pelvic inflammatory disease
  The PCP shall provide follow up care or refer the member further for follow up treatment where indicated.

Family Planning services for sterilization do require prior notification authorization and should be performed by contracted panel providers. A human sterilization consent form [PM330 or PM284 for Non-Federally Funded Plans] will be signed by both the physician and member 30 days prior to the date of service with the planned date of service as per Title 22, Section 51305 (1), (2), (3), (4). The Consent Form must also accompany the claim for payment of service. Patient to be sterilized must be at least 21 years of age at the time the consent for sterilization is obtained, not mentally incompetent, able to understand the content and nature of the informed consent process, is not institutionalized and has signed and dated the consent form. The physician or the physician's designee reviewing the informed consent with the member also provides the individual with a copy of the consent form NEW Provision of DHCS Booklet on Sterilization and is documented in the medical record. An interpreter is provided if there is evidence that the patient does not understand the language and/or text of the informed consent process.

The PM284 human sterilization form for [Non-Federally Funded Plans] will be signed and dated by the member, physician, and interpreter if one is provided. The member must be at least 18 years of age, and if under the age of 18 entered into a valid marriage, or active duty with the U.S. armed services, or received a declaration or emancipation pursuant to Section 64 of the Civil Code. Members who have received declaration or emancipation and are 15 years of age must live apart from their parents or guardians, manage their own financial affairs has voluntarily given consent, mentally competent, understands content and nature of informed consent and not institutionalized at the time of consent.

Sterilization is performed at least 30 days, but not more than 180 days, after the date upon which informed consent was obtained for the sterilization, except in cases involving emergency abdominal surgery or premature delivery in which specific requirements are documented to have been met. The

Physician Completes section information as applicable and signs and dates the PM 330 or PM284 consent forms.

Members may request a Sensitive Service Confidential Communication concerning communication related to any sensitive services. AB1184 prohibits the disclosure of medical information related to sensitive services to anyone other than the Protected Individual/Enrollee (including the policyholder or parent of a minor patient without the Enrollees express written authorization). Confidentiality must be protected regardless of method of requested communication. All communication regarding sensitive services will be sent directly to the Enrollee at the current address on file unless the enrollee has otherwise designated an alternative address. These requests will be flagged in the system eligibility file for the member.

Absent clinical contraindications, the group will not impose utilization controls limiting the supply of FDA-approved, self-administered, hormonal contraceptives dispensed or furnished by a provider, pharmacist or other authorized locations to an amount that is less than a 12-month supply.

The IPA will provide a 12-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a members request by a qualified family planning provider or pharmacist, including out-of-network providers.

Hepatitis C Treatment -

The providers will utilize guidelines set forth in the Treatment Policy for Management of Chronic Hepatitis C. See https://dhcs.ca.gov/Documents/Chronic-Hep-C.pdf. This includes Treatment Considerations and Choice Regimen for Hepatitis C Virus Infected patients (DHCS recommends referring AASLD guidelines for recommended treatment) regimens and durations, Identifying Treatment Candidates, Patient Readiness and Adherence, Age Requirements, Quantity Limits, Criteria for Reauthorization/Continuous Therapy, Laboratory Testing and Populations Unlikely to Benefit from Treatment Retreatment. Utilization Management protocols are medically reasonable and will not impede access to treatment. Providers will be informed of guidelines and access to the guidelines.

Minor Consent Services -

Minor Consent Services include treatment for sexual assault, drug, and alcohol services for children 12 years or older, Pregnancy, Family Planning, STD, and outpatient mental health services for children 12 and over who are determined to be mature enough to participate intelligently and where there is a danger of serious physical and mental harm to the minor, or when the minor is an alleged victim of incest or child abuse. These services do not need parental consent. The IPA will not inform Parents of a Minor's Sensitive Services information without the Minor's written consent.

Minor Consent for individuals under 18 years of age shall be available within the provider network and members shall be informed of the availability of these services. However sensitive services may be accessed out of network. [See Sensitive Services above].

Emergency Services –

Do not require prior authorization. (See UM5 Emergency and Urgently Needed Services) This includes but is not limited to Urgent Care for home and community-based members and crisis stabilization for mental health.

Mammography

Upon the referral of a nurse practitioner, physician assistant, certified nurse midwife, or physician, providing care to the patient and operating within the scope of practice for breast cancer screening or diagnostic purposes.

Mammography for Medicare Members

Medicare members must have access to mammography services through self-referral to any provider. A list of mammography providers contracted with the IPA can be mailed to Medicare members on an annual basis.

Influenza Vaccinations (Flu Shots) for Medicare Members

Medicare members must have access to influenza vaccinations (flu shots) through self-referral to any provider. A list of influenza vaccine providers contracted with the IPA can be mailed to Medicare members on an annual basis at the beginning of the influenza season.

Human Papillomavirus Vaccine (HPV)

For all ages 9-26 years of age and for those 13 to 26 years of age who have not been vaccinated previously or have not completed the full vaccine series are offered the Gardasil vaccination against HPV. The PCP and OB/GYN will inform members that Gardasil is a benefit for women ages 9-26 that are not pregnant and may be effective for prevention of cervical cancer and is recommended as part of routine preventive services.

Initial Consultations to Specialists

LA Care Health Plan

IPAs will allow initial consultation to contracted IPA providers for their LA Care Health Plan membership. The PCPs are encouraged to utilize the Direct Referral Form; however, claims will not be denied for initial consultations if no form is on file. Members will also be granted same day access for care when requested.

OneCare:

IPAs will allow Direct Referrals for initial consultations for Cardiology, Dermatology, Endocrinology, Otolaryngology, Gastroenterology, General Surgery, Hematology, Nephrology, Neurology, OB/Gyn, Oncology, Ophthalmology, Orthopedics, Pulmonology, Rheumatology and Urology. In addition, OneCare members must have Direct Access to routine Radiology and Lab services, Annual Well Woman exam, Prenatal Exam and OB Care, Annual Eye Exam, professional services related to Audiology and Family Planning Services.

PROCEDURE:

None required. Providers may order tests and/or send members for these services without prior authorization. Members may self-refer to services listed as such.

For Medi Medi, a member may self-refer for out of area renal dialysis, communicable disease services including STI and HIV testing, emergency and post stabilization services including emergency behavioral health care, urgent care, crisis stabilization including mental health, urgent care for home and community service-based members, family planning, preventive services, and basic prenatal care.

Consultation & Follow Up After Direct Access– The physician providing service will consult with the member's Primary Care Physician regarding the member's condition, treatment and any need for follow up care. If the member's need for follow up care does not meet the Self-referral or Direct Access Indication guidelines, the Primary Care Physician will obtain copy of treatment notes and a referral for services will be submitted to the UM Department following referral policy.

Claims Reimbursement – No prior authorization will be required for payment of the services in this policy. With the exception of members with Medi-Cal plans, members may be held financially responsible if services are rendered outside the scope without prior authorization. "Carve out" services are not the IPA's financial responsibility.

FORMS:
Direct Access Referral Authorization
Direct Access Criteria

REFERENCES:
UM 5 - Emergency and Urgently Needed Services
CA Health and Safety Code 1371.4 (a)
AB 12: Direct Access to Obstetrician-Gynecologist (1999)
AB 2186: Pediatric Asthma Care (1/1/2005)
CA Civil Code 56.107(1); AB1184
APL 22-010 Cancer Biomarker Testing
APL 22-022 Abortion Services

[i] California State AB12 – OB/GYN Self-Referral effective 1/1/99.

[ii] Dept. of Health Services requirement under LA County two-plan model, Cal Optima and other Medi-Cal managed Care programs.

SUBJECT: New Technology Experimental Treatment **Policy #:** UM8
DEPARTMENT: Utilization Management

Effective Date: June 3, 1997
Last Revision Date: September 13, 2021
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define and clarify the process for reviewing authorization requests that may be considered new technology or experimental treatment. This includes but is not limited to drugs, devices, procedures, or other therapy such as clinical trials for members with a life threatening or seriously debilitating condition.

POLICY:

Upon receipt of a request, initial research to assist in the determination may be made in accordance with the Utilization Management Referral procedural guidelines.

The UM Coordinators will review the health plan's medical policy and benefit exclusions to assist with initial determination. All questionable "experimental" requests will be referred immediately to the Medical Director, Physicians Reviewer or UM Committee for further clarification.

Unless otherwise delegated, approval for New Technology/Experimental Treatment will be deferred to the health plan for final determination within 24 hours of determination that request is experimental. Expedited requests must be faxed to the health plan on the same day if a member or physician requests.

Per SB37: Routine care will be provided for any member participating in Clinical Trials for Cancer. The enrollee must be diagnosed with Cancer and must be accepted into Phase I, Phase II, Phase III or Phase IV clinical cancer trials. If determined that the member meets the criteria for clinical cancer trial, the treating physician of the member must recommend participation.

Any request for Clinical Trials for Medicare Advantage members must be reviewed directly by CMS.

Health and Safety Code section 1370.6 and the Affordable Care Act a customer accepted into a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition, will provide coverage when delegated for all routine patient care costs related to the clinical trial when criteria is met.

Requests for clinical trials reviewed on a case-by-case basis to determine medical necessity and to assure that the criteria in the law are met. Drugs, items, devices, and services will be covered only when delegated and in trials where the research sponsor (or other party to the clinical trial) does not provide these items or services.

When covered, these will be payable as other drugs, items, devices, and services are covered absent a clinical trial.

Approval for a Qualified Member accepted into phase I, phase II, phase III, or phase IV eligible clinical trial will be obtained from the plan. The group will provide coverage for all routine patient care costs related to the clinical trial consistent with the law.

DEFINITION:

New Technology/Experimental: any procedure, treatment, therapy, drug, or supply that when compared with conventional means of treatment or diagnosis, has not been demonstrated as a safe and or effective in the treatment of a specific illness, injury, or condition. This may refer to clinical trials, investigational or educational services and treatment.

Life Threatening: Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Qualified Members for Clinical Trials: The plan are responsible for final determination. A qualified member is an enrollee who meets both of the following conditions:

1) The enrollee is eligible to participate in an Approved Clinical Trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition; and

2) Either of the following applies:
   • The referring health care professional is a participating provider and has concluded that the enrollee's participation in the clinical trial would be appropriate, or

   • The member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate.

Routine Patient Care Costs: Include drugs, items, devices, and services, where delegated and approved by the member's health plan, provided consistent with coverage under the contract for a member who is not enrolled in an Approved Clinical Trial, including the following:

1) Drugs, items, devices, and services typically covered absent a clinical trial.
2) Drugs, items, devices, and services required solely for the provision of an investigational drug, item, device, or service.
3) Drugs, items, devices, and services required for the clinically appropriate monitoring of the investigational drug, item, device, or service.
4) Drugs, items, devices, and services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
5) Drugs, items, devices, and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis and treatment of complications.

Routine Patient Care Costs does not include the following:

1) The investigational drug, item, device, or service itself.
2) Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the enrollee.

3) Drugs, items, devices, and services specifically excluded from coverage in the contract, except for drugs, items, devices, and services required to be covered pursuant to this section or other applicable law.
4) Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

Seriously Debilitating: Disease or conditions that cause major irreversible morbidity.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing death.

- CMS Benefit Manual, Chapter 9, Section 10 states: "An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course."
- California Health and Safety Code 1373.96 states: (4) A terminal Illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.

PROCEDURE:

A. The Medical Director, Physician Reviewer or UM Committee will determine if further research or investigation is appropriate to determine if a service is considered experimental.

1. The Authorization may be pended during this research process.

2. Additional information may be sought from conducting a literature search, including review of information from national organizations, scientific literature, professional specialists, experts and appropriate regulatory agencies.

3. A consultation with a physician, board certified in the applicable specialty may also be done.

B. The Medical Director or Physicians reviewer will consult with the member's health plan Medical Director within 24 hours for final evaluation and determination.

C. All requests for Experimental and Investigational treatment must be reviewed and authorized by the member's Health Plan. For Medicare Advantage members in the case of Clinical Trails, the case must be reviewed by CMS.

1. The group may be responsible for authorizing pre-trial services not covered by the clinical trial program.
2. The group will continue to authorize routine care outside of the clinical trial.

D. For all final determinations received from the health plan, the group will follow instructions for issuing appropriate notifications where necessary using the established guidelines for approvals or denials, second opinions etc.

FORMS: Referral Authorization Worksheet

REFERENCES:

NCQA UM 1: Program Structure
NCQA UM 8: Policies for Appeals
NCQA UM 9: Appropriate Handling of Appeals
NCQA UM 10: Evaluation of New Technology

SUBJECT: Concurrent Review/Discharge Planning **Policy #:** UM9
DEPARTMENT: Utilization Management

Effective Date: June 14, 1997
Last Revision Date: February 6th, 2025
Last Review: February 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure that the care of hospitalized members is reviewed on a concurrent basis in order to determine accurate and timely service delivery at an appropriate level of care.

To ensure that member's progress is evaluated to plan for coordination among all disciplines; identification of case management referral needs; identification of any potential quality issues; and timely discharge planning.

POLICY:

Concurrent Review/Discharge Planning will be conducted on all hospitalized members by licensed staff. This review includes coordination of telephonic reviews, on-site reviews by hospital Case Managers or plan nurses and chart review.

There will be on-going communication with all healthcare professionals involved in the members' care. This includes the contact between the Concurrent Review Nurse, Medical Director, Primary Care Physicians, Attending Physicians, Discharge Planners, Case Managers, health plan, etc.

Clinical Guidelines will be applied in a consistent manner to justify medical necessity and length of stay. Criteria is applied using Policy and Procedure UM2 (Medical Review Criteria), ensuring the needs of the individual in consideration of age, medical necessity, estimated length of stay, intensity of service & severity of illness, appropriate level of care, service area, co-morbidities, complications, home environment, progress of treatment and psychosocial needs. Benefit verification will occur to ensure the proper authorization and management of services delivered.

Under the Two Midnight Benchmark, surgical procedures, diagnostic tests and other treatments will generally be considered appropriate for inpatient hospital admission and payment under Medicare when the physician expects the patient, based on specific complex medical factors documented in the medical record (such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of adverse event), to require a hospital stay that crosses at least two midnights and admits the member to the hospital based upon that expectation.

A preliminary discharge plan should begin prior to the patient's admission for all planned admissions. For all other admissions, discharge planning at time of the member's admission will be an integral part of the management team's assessment and management of care.

Discharge planning in conjunction with Hospital Case Managers includes but is not limited to, assessing pre-discharge factors including an understanding of the member condition by the Member or their representative including physician and mental function, financial resources and social supports and an assessment of type of placement needed upon discharge, including type of placement preferred by the member/representative, type of placement member/representative agrees to, specific agency/home recommended by the Hospital, Agency/Home member/representative agrees to and pre-discharge counseling.

Chronic or complex cases will be referred to for Case Management. The Utilization Management Committee will do a focus review of all complex cases.

If at any time the Medical Director and Treating Physician are in disagreement about the safety and necessity of treatment and/or transfer, the case will be reviewed by the UM Committee. The UM Committee may request that one of the contracting providers take over care of the member. Care shall not be discontinued until the treating provider has been notified and agrees to a care plan that is appropriate for the patient's medical needs.

The Concurrent Review Nurse will monitor that the Hospital has issued an Important Message from Medicare [IM] within 2 calendar days of admission and not more than 2 calendar days prior to discharge for all Medicare inpatient hospital admission. In addition, the Concurrent Review Nurse will ensure the hospital has delivered of the Medicare Outpatient Observation Notice [MOON] for Medicare members receiving Observation services in a hospital setting. For plans requiring a copy of MOON, the Concurrent Review Nurse will obtain a copy and forward to the Plan and a copy kept with the member admission record.

For Medi-Cal members in an acute inpatient setting, where the attending provider or member elects' participation in Voluntary Inpatient Detoxification [VID], a review of criteria for VID will occur to determine coordination of service. If determined to not meet criteria after clinical evaluation by a physician, coordination will occur with County Behavioral Health for referral to other medically necessary substance abuse disorder treatment services. If determined to meet criteria, coordination with the local Medi-Cal FFS field office will occur, and the VID admission is authorized and covered by Medi-Cal FFS. The Concurrent Review Nurse and/or Case Manager will assist in coordination as appropriate. Any medical related services during a VID admission may be coordinated with the Concurrent Review Nurse.

DEFINITIONS:

Criteria: A Standard or measure by which a decision can be made; a model or test

Initial Determination: A decision of medical need based on information provided to the reviewer either prior to service or at the time of first review following inpatient admission.

Concurrent Review: An assessment of medical necessity or appropriate services as services is being rendered while the member is in the process of treatment.

Skilled Service Criteria:

Discharge Planning: Comprehensive evaluations of needs in order to arrange for appropriate care after discharge to include but is not limited to: Documentation of pre-admission or baseline status; Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community-based LTSS programs; Initial coordination of care, as

appropriate with the member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the member's care coordinator contact information is readily available for hospitals; and Provision of information for making follow-up appointments.

Retrospective Review: An assessment of appropriate medical services after services have been provided.

Case Management: The process of determining the health needs of an individual, designing and implementing a plan of care to effectively use available resources with the objective of improving patient outcomes.

PROCEDURE:

CONCURRENT REVIEW

A. Notification of admissions may come to the Concurrent Review Nurse from the hospital's admitting department or Case Manager assigned to the case, the member's Primary Care Physician, the Medical Director, and/or the health plan.

B. The Concurrent Review Nurse will notify the Medical Director and PCP of all admissions within 24 hours of receipt of notification.

C. Notification to the member's health plan will be determined by the IPA's contract with the plan. In some cases, the hospital has the responsibility to notify the health plan directly.

D. Urgent Concurrent decisions are reported to the hospital case management/UR department staff with the understanding that the staff will inform the attending/treating practitioner. Notifications may be addressed to the hospital CM/UR Department to the attention of the attending or treating provider.

E. Upon notification of a case for which there may be a potential CCS eligible condition, the case will be coded as CCS and followed through determination of CCS eligibility [See CCS policies UM25 CCS and UM45 Whole Child Model]. For CCS eligible neonates in the NICU/PICU, at anytime during the admission, should the member lose Medi-Cal coverage, the County CCS Agency will be notified in writing within 15 days.

F. An intake sheet will be utilized to document notification of admissions. The intake sheet will be faxed to the Medical Director and Primary Care Physician.

G. When notification is made on an out of area/plan admission, the Concurrent Review nurse, under the direction of the Medical Director, will assist to transition the member to an in-plan facility at the time the member is stable for transfer. In some cases, the out of area Concurrent Review process is the health plan's responsibility, unless otherwise delegated.

H. The Concurrent Review Nurse will verify if an authorization was made prospectively, assigning that number to the case. For all emergency admits, authorization will be processed through the referral authorization guidelines.

I. All admissions will be initially reviewed within 24 hours after the admission occurs or immediately if the admission occurred more than 24 hours prior to notification.

J. Each assessment of a member's care will be made for medical necessity, appropriateness, and level of care. Essential information to evaluate severity of illness and intensity of services include:

1. Primary and secondary diagnosis
2. Vital signs and labs
3. IV or Transfusion activity
4. Procedures/studies planned by attending & specialists
5. Intubation, lines, monitors, NG tubes, drains, etc.
6. Transfer plans

K. The Concurrent Review Nurse will attempt to get a daily review of all acute cases and will work closely with the hospital case manager. In some cases, such as pregnancy, initial review and review before discharge may only be required.

1. SNF admissions will be reviewed at least weekly.

L. All assessments, actions and additional days for admissions are documented and discussed with the Medical Director to assure they are justified and meet medical necessity. The Medical Director will be contacted immediately if the inpatient care is questionable, complex, controversial, or seemingly inappropriate.

M. Any case absent a plan, where discharge is imminent, requires review by the Medical Director.

N. If the Attending Physicians does not agree with the Medical Director, the case will be reviewed by the UM Committee. The UM Committee may request that another contracted provider accept the transfer of the member's care.

O. If a decision is made to deny hospital care, a denial process will occur according to the Denial Policy and a concurrent review denial letter sent the same day, according to the member's health plan and/or line of business.

P. All potential quality issues that arise from an inpatient admission are reported to the Quality Management Committee.

Q. Care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

R. When a member's condition indicates a transition from the acute care setting to a SNF or Sub-Acute and the treating provider has approved the transition, the transition will occur within 72 hours from the time of the request. If placement exceeds 72 hours, the concurrent review nurse will coordinate with the facility case manager to facilitate a transfer to the most appropriate level of care based on medical necessity and incorporate the member's preferences when medically appropriate.

DISCHARGE PLANNING

A. Discharge planning is the responsibility of the Attending Physician with the support of the Concurrent Review Nurse and Case Managers, IPA Medical Director, and hospital Discharge

Planner. This "team" will coordinate efforts to conduct time and appropriate discharge activity and should begin on the day of admission.

B. The Concurrent Review Nurse/Case Manager will consider and document the pre-admission status prior to the member's discharge and ensure member, caregiver/family member's understanding of the current conditions. This includes but may not be limited to:

1. Medical and functional condition
2. Medications, Infusion
3. Supplies, DME
4. Member, caregiver/family members placement preference
5. Pre-discharge counseling
6. SNF, Hospice and/or applicable Community Resources and programs
7. Special assistance, Home Health Nurse/Aide
8. Living arrangements,
9. Physical and mental function
10. Social Support
11. Financial support
12. Further institutional care
13. Transportation needs
14. Hospice
15. Identification and integration of community based LTSS programs
16. Other special needs

C. Hospice Services shall be provided for members whose prognosis indicates a life expectancy of one year or less. Authorization for hospice services either by the plan or by the IPA will cover a certification period of two 90-day periods and an unlimited number of 60-day periods and must be provided by a Medicare certified provider. Covered hospice services must be available on a 24-hour basis to meet the needs of the member's care, to manage the terminal illness and any related conditions. In some cases, Hospice services may be authorized by the health plan. All Hospice cases will be referred to Case Management.

D. Home Health

Home Health review for initial or continued home health requests shall be conducted as often as necessary as determined by UM Criteria and the discharge planning process. Decisions to discontinue, change or terminate services are provided with the appropriate organization determination and within the established UM decision making timeframe.

E. All elective patient admissions should have a preliminary discharge plan and expected length of stay initiated prior to hospitalization. This process will be initiated at the time of admission for emergent and urgent cases without a preliminary plan and immediately upon notification of out of plan hospitalizations.

F. Discharge from the hospital will not be delayed as a result of a lack of plan.

G. Skilled therapy service requests [SNF, HH, PT/OT/Speech Therapy] will not be denied based on the absence of potential for improvement or restoration. Services will be reviewed based on member's medical condition and requirement of skilled care that is reasonable and necessary to prevent or slow further deterioration, which may include training of family/caregiver. To be considered a skilled

service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical staff. Or a condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation staff.

H. All discharge plans will be reviewed for member benefit prior to implementation. In the event that the benefit is not covered or provided through the health plan, and in the judgment of the attending provider and/or Medical Director the benefit should be provided to prevent harm and continued hospitalization, the service may be authorized.

I. Activity where discharge planning support may be required by outpatient Case Management, Community Resources or other support agency may be:

1. Neurological discord, including stroke
2. Intracranial neurosurgical procedures
3. Malignant Disease process
4. Major Joint replacement procedures
5. Major Trauma and Orthopedic procedures
6. Long Term Care
7. Antibiotic, Parental and or enteral therapy
8. Pain management
9. Prior Nursing home, convalescent, and residential care residents
10. New amputees
11. New permanent ostomy
12. Potential hospice cases
13. Chronic illnesses
14. Members without family or support services
15. Any condition that occurs as a result of a member's inpatient care requires that the Concurrent Review Nurse consider the need for a Case Management Referral. Other types of cases where this may be necessary would-be readmission cases, high risk, carve out cases, etc. The Concurrent Review Nurse would then refer the case-to-Case Management after discharge. (See Case Management policy.)

G. The Concurrent Review Nurse will maintain a log of all inpatient stays for health plan reporting. (See Health Plan Reporting policy). Per the contractual agreements with the individual plan(s), and within the specified time frames, the health plan will be notified of complex, high risk or stop loss cases.

H. A report of all inpatient Activity is reviewed by the UM Committee as prepared and presented by the Concurrent Review Nurse.

I. All potential quality issues will be reported to the Quality Management Committee.

FORMS:
Concurrent Review Log Sheet
Concurrent/Facility Review

REFERENCES:
NCQA UM1

SUBJECT: Doula Services **Policy #:** UM 48
DEPARTMENT: UM/CM Departments

Effective Date: February 23rd, 2024
Last Revision Date: February 15th, 2024
Last Review: January 2026

SCOPE:
This policy applies to the Medi-Cal line of business.

PURPOSE:
This policy describes the eligibility criteria for Doula services, identifies the qualifications for becoming a Doula provider, and provision of Doula services as a benefit. If the service is a benefit of the member's health plan but the IPA is not delegated review of the service, the request will be forwarded to the health plan.

POLICY:
The IPA will provide Doula Services for prenatal, perinatal, and postpartum Members, regardless of pregnancy outcome, when it is recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under the state law.

The Department of Health Care Services (DHCS) issued a statewide standing recommendation that all Medi-Cal members who are pregnant or were pregnant within the past year would benefit from receiving doula services from a Medi-Cal enrolled doula provider. The recommendation fulfills the federal requirement for a physician or other licensed practitioner of the health arts acting within their scope of practice to provide a written recommendation for preventive services.

The IPA will provide Doulas with all necessary, initial, and ongoing training and resources regarding relevant services and processes, including any available services for prenatal, perinatal, and postpartum Members in accordance with health plan requirements.

1. Training must be provided initially when a Doula is enrolled with the IPA, as well as on an ongoing basis.
2. The IPA will provide technical support in the administration of Doula Services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by the Department of Health Care Services (DHCS).

Network Providers, including those who will operate as Providers of Doula Services, are required to enroll as Medi-Cal Providers, consistent with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013:

The IPA will ensure and monitor sufficient Provider Networks within their service areas, including Doulas, in accordance with Access and Availability Standards.

1. The IPA will collaborate with network hospitals/birthing centers to ensure there are no barriers to accessing these Providers when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).
2. IPA will coordinate with the Health Plan for Out-of-Network (OON) access to Doula Services for members if an In-Network Doula provider is not available for Medically Necessary services.

3. If a Member desires to have a Doula during labor and delivery, the IPA will work with In-Network hospitals and birthing centers to allow the Doula, in addition to the support person(s), to be present.

Receiving Doula Services does not limit Members from receiving Perinatal Support Services (PSS) through Comprehensive Perinatal Service Program (CPSP).

DOULA REQUIREMENTS AND QUALIFICATIONS:
All Doulas must be at least eighteen (18) years old, provide proof of an adult and infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red cross or American Heart Association, and attest they have completed basic Health Insurance Portability and Accountability Act training. A Doula must qualify by meeting either the training or experience pathway, as described below:

1. **Training Pathway:** Provide a certificate of Completion for a minimum of sixteen (16) hours of training which includes all of the following topics:
   a. Lactation support.
   b. Childbirth education.
   c. Foundations on anatomy of pregnancy and childbirth.
   d. Nonmedical comfort measures, prenatal support, and labor support techniques; and
   e. Developing a community resource list.
   f. Attest that they have provided support at a minimum of three (3) births.

2. **Experience Pathway:** All of the following:
   a. Attest that they have provided services in the capacity of a Doula in either a paid or volunteer capacity for at least five years. The five years of experience in the capacity as a Doula must have occurred within the last seven (7) years.
   b. Provide three (3) written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health Provider, nurse practitioner, nurse midwife, licensed midwife, enrolled Doula, or community-based organization.
   c. Letters must be written within the last seven years. One (1) 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 the Health Plan.

3. **Continuing Education:**
   a. The IPA must ensure Doulas complete three (3) hours of continuing education in maternal, perinatal, and/or infant care every three (3) years.
   b. Doulas must maintain evidence of completed training to be made available to DHCS upon request.

PROCEDURE:

Doula Services can be provided virtually, via Telehealth and other Technology-Enabled Services, or in person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers. When Doulas services are not delegated to the IPA, all recommendations will be submitted directly to the health plan.

A Doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a Doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care).

a. The visit must be face-to-face, and the assistive or supportive service must be incidental to Doula Services provided during the prenatal or postpartum visit.
b. The Member cannot be billed for the assistive or supportive service.

The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a Network Provider with the Health plan.

1. **Initial Recommendation**

An initial recommendation for Doula Services can be provided through:

a. A written recommendation in the Member's record.
b. A standing order for Doula Services by the HealthPlan or the IPA, physician group or other group by a licensed Provider, the Department of Health Care Services (DHCS); or
c. The standing recommendation issued by DHCS on November 1, 2023, fulfills this requirement until the time it is rescinded or modified.
d. A standard form, such as the DHCS Medi-Cal Doula Services Recommendation or Health Plan Recommendation Form(s), signed by a physician or other licensed practitioner that a member can provide to a Doula.

2. **The Initial recommendation includes the following authorizations:**

a. One initial visit.
b. Up to eight (8) additional visits that can 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; and
d. Up to two (2) extended three (3) hour postpartum visits after the end of a pregnancy.

The extended three (3) hour postpartum visits provided after the end of pregnancy do not require the Member to meet additional criteria or receive a separate recommendation.

Doulas should work with the Member's Primary Care Provider (PCP) or work with the Health Plan or IPA to refer the Member to a Network Provider who is able to render the service, if a Member requests or requires pregnancy-related services that are available through Medi-Cal.

1. 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; and
   k. Medically appropriate Community Supports services.

Eligibility Criteria for Doula Services

1. To be eligible for Doula Services, and be covered under Medi-Cal managed care, a Member must be eligible for Medi-Cal, enrolled in a health plan, and may have recommendation for Doula Services from a physician or other licensed practitioner of the healing arts.

2. Medi-Cal Eligibility Checks: Doulas must verify the Member's Medi-Cal enrollment for the month of service. Doulas must contact the Member's IPA or Health Plan to verify eligibility.

3. Recommendation for Doula Services: A Member would meet the criteria for a recommendation for Doula Services if pregnant, or pregnant within the past year, and would either benefit from Doula Services or if they request Doula Services. Doula Services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a Member's pregnancy.

Documentation Requirements

1. Doula Services may provide an optional recommendation by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law prior to Doula services being provided.
2. Initial recommendations can be provided through approved methods as outlined in section III.C.1

Secondary recommendations are required for additional visits during the Postpartum period.

a. A recommendation for additional visits during the Postpartum Period cannot be established by standing order.
b. The additional recommendation authorizes nine (9) or fewer additional postpartum visits.

The IPA will ensure Doulas document the dates, time, and duration of services provided to Members.

a. Documentation must also reflect information on the service provided and the length of time spent with the Member that day.
b. Documentation should be integrated into the Member's medical record and available for encounter data reporting in accordance with Health Plan Encounter Reporting Requirements.
c. The Doula's National Provider Identifier (NPI) number should be included in the documentation.
d. Documentation must be accessible to the Health Plan and DHCS upon request.

Non-Covered Doula Services:

Doula Services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

1. The following services are not covered under Medi-Cal or as Doula Services:

a. Belly binding (traditional/ceremonial).
b. Birthing ceremonies (i.e., sealing, closing the bones, etc.).
c. Group classes on baby wearing.
d. Massage (maternal or infant)
e. Photography
f. Placenta encapsulation.
g. Shopping.
h. Vaginal steams; and
i. Yoga

Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing Doula Services.

UTILIZATION MANAGEMENT:
Prior authorization for Doula services is not required. Providers can submit the *"optional"* recommendation form for services to the claims department for reimbursement.

CASE MANAGEMENT:
Case Management (CM) services are available to assist members with accessing and coordinating Doula services. Case referrals can be received from the members, providers, and Member Services. CM services includes but not limited to, educating members on the roles and responsibilities of a Doula during the prenatal and postpartum periods of care, assisting in identifying an approved Doula, sharing information with the member's providers, attaching associated records to the member's case, and referring to the appropriate designated staff for billing inquiries.

ATTACHMENTS (S)

Not Appliable

REFERENCE (S)

Cal Optima Health's Policy for Doula Services (GG.1707)
Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment
Department of Health Care Services (DHCS) All Plan Letter (APL) 23-020: Requirements for Timely Payment of Claims
Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services
Department of Health Care Services (DHCS) Medi-Cal Provider Manual – Doula Services
Title 42, Code of Federal Regulations (CFR), §440.130(c)

DEFINITIONS

Term	Definition
Doula	Birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth, and abortion, with the goal of preventing perinatal complications and

	improving health outcomes for birthing parents and infants. Doulas are not licensed or clinical, providers, and they do not require supervision.
Doula Services	Doula Services encompass health education, advocacy, and physical, emotional, and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the Postpartum Period.
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service.
Postpartum Period	Doulas may provide services for up to twelve (12) months from the end of pregnancy. Beneficiaries are eligible to receive full-scope Medi-Cal coverage for at least twelve (12) months after pregnancy.

SUBJECT: Federal Disaster PHE Emergency **Policy #:** UM49
DEPARTMENT: Utilization Management

Effective Date: July 9th, 2024
Last Revision Date: July 9th, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure compliance with all State and Federal requirements for authorizations, claims processing and coordination of services during a declaration of disaster or public health emergency. The MSO and its managed IPAs will adhere to the following.

POLICY:

The IPA will implement the following measures to ensure members will continue to have access to services during a declaration of a disaster or Public Health Emergency.

1. Allow Part A and Part B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities (note that Part A and Part B benefits must, per 42 CFR §422.204(b)(3), be furnished at Medicare certified facilities).

2. **Waive in full,** requirements for gatekeeper referrals where applicable.

3. Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts; and

4. Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.

5. As with all disaster declarations, all enrollees must have adequate access to medications dispensed at an out of network pharmacy when they cannot reasonably be expected to obtain at a network pharmacy.

6. Plans are expected to lift their "refill-too-soon" edits. Plans have operational discretion as to how these edits are lifted during a disaster or emergency as long as access to the medication is provided at the point of sale and are expected to allow an affected enrollee to obtain the maximum day supply, if requested and available at the time of refill. Plan's may also extend the implementation of their "refill-too-soon" edits past the expiration of the declaration. However, should the edit be removed, the plan needs to work closely with the enrollees who indicate that they are still displaced or otherwise impacted by disaster or emergency.

7. Specifically, in compliance with CA AB 2941 State of Emergency Mandate:

    - The IPA will provide members who have been displaced, or with a potential to be displaced, by a state of emergency, access to medically necessary health care services within 48 hours after the emergency has been declared by the Governor.

      If a member has an authorization in place and has had to change the location or provider due to circumstances stemming from a State of Emergency, authorizations for a different location or provider will be honored. Standard and Urgent requests will be monitored for members in the affected designated area. The IPA will provide access to care, support or authorize as in-network, out of network physicians if in- network services are not available or otherwise affected by the State of Emergency.

    - Out-of-network claims will be flagged that are related to affected designated areas and will extend the claims filing deadlines, waive denials related to untimely filings, and use pre-paid audits to minimize inappropriate denials of claims.
    - A 24/7 telephone number for enrollees to call with questions and concerns regarding their health care coverage is available.

8. Allowances will be made for:
    a. Relax time limits for prior authorization, precertification, or referrals.
    b. Extend filing deadlines for claims.
    c. Suspend prescription refill limitations and allow an impacted enrollee to refill his or her prescriptions at an out-of-network pharmacy.
    d. Authorize an enrollee to replace medical equipment or supplies.
    e. Allow enrollees access to an out-of-network provider if an in-network provider is unavailable due to the state of emergency or if the enrollee is out of the area due to displacement.

9. Upon notification, staff will be educated on the requirements during a state of emergency. A review of potential risk by geographical location will occur. UM staff may document on referral activity, notes to system, etc., to ensure claims are paid appropriately and timeliness parameters are waived.

<u>Specific to the COVID-19, the MSO and its managed IPAs will adhere to the following</u>:

1) Cover all medically necessary emergency care without prior authorization, whether that care is provided by an in-network or out-of-network provider.

2) Comply with utilization review timeframes for approving requests for urgent and non-urgent covered services.

3) Waive prior authorization requests for services, including screening and testing, related to COVID-19.

4) Ensure adequate access to handle an increase in the need for services, including offering access to out-of-network services where appropriate and required, as more COVID-19 cases emerge in California.

5) Ensure members are not liable for balance bills from providers, including balance bills related to testing of COVID-19.

6) Ensure 24-hour access to a representative with the authority to authorize services.

7) Offer members and providers the option to utilize telehealth services to deliver care when medically appropriate, as a means to limit members' exposure to others who may be infected with COVID-19.

8) Approve transportation requests in a timely manner if a member, who may be infected with COVID-19, needs to be seen in person and requests transportation.

9) As per APL-20-006 COVID-19 Screening and Testing Will waive co-pays and cost share for the diagnostic laboratory test for COVID-19 and will cover the test kit for patients who meet CDC guidelines for testing, which can be done in any approved laboratory location. No Prior Authorization is needed for this testing and can be obtained in or out of network.

10) Will offer zero co-pay and cost share for participating telemedicine visits Members may use telemedicine as their first line of defense in order to limit potential exposure in physician offices. Cost sharing will be waived for all video visits by in-network providers delivering synchronous virtual care (live videoconferencing) for those plans that cover this type of service.

11) Co-pays and cost share for office visits, urgent care visits, and ED visits where the diagnosis rendered is specifically related to COVID-19. Visits for other symptoms or diagnoses will not have co-pay or cost share removed. This includes not removing cost share for other laboratory testing (besides COVID-19 testing), x-rays, or other add-on testing.

12) Refill timing will be relaxed to allow refills up to 7 days early and requests may be made for 90-day prescription and refills.

COVID-19 is a mandated reportable condition by law in accordance with Title 21 health and safety code. Providers must report positive COVID-19 lab results to public health departments of member's jurisdiction, within one day.

DEFINITIONS:

None required.

PROCEDURE:

The Health and safety of our members and employees is our priority. As with any public health issue the MSO will implement the following.

1. The MSO will work with the health plans and follow all guidance and protocols issued by the CDC, state and local public health departments regarding COVID-19.

2. The MSO will take multiple steps to minimize health risks to our teammates, our clients and our communities, including enhanced cleaning procedures. Staff who are ill are encouraged to remain at home and will be provided with telework options that are available when job requirements allow.

3. The MSO will continue to disseminate updates/information/education materials received from the various health plans to staff and providers, as directed.

4. The MSO will assess daily staff assignments to ensure member care and timely processing is not interrupted. Staff may be deployed to telework as their positions allow, as identified. Some staff will remain on-site to ensure timely mailing activity.

5. The MSO will be closed to visitors and will limit meetings on an as needed basis or conduct them via Webinar.

FORMS:
None

REFERENCES:
CA AB 2941 State of Emergency Mandate 2022 SB 979 Section
Amendments to Section 1368.7 of CA Health and Safety Code Section 2. Amendments to Section 10112.95 of the Insurance Code.

DMHC APL 23-002 (OPL) Senate Bill 979 - Health Emergencies Guidance

SUBJECT: Artificial Intelligence Technology **Policy #:** UM50
DEPARTMENT: Utilization Management

Effective Date: March 10th 2025
Last Revision Date: March 10th, 2025
Last Review: March 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:
To ensure that utilization review or utilization management functions are based in whole or in part on medical necessity. If the organization uses artificial intelligence, algorithms, or other software tools for utilization review or utilization management functions, medical necessity decisions will comply with SB-1120. These standards apply to utilization management functions that prospectively, retrospectively, or concurrently review requests for covered services.

POLICY:
Artificial intelligence, algorithms, or other software tools shall not deny, delay, or modify health care services based, in whole or in part, on medical necessity. A determination of medical necessity shall be made only by a licensed physician or a licensed health care professional competent to evaluate the specific clinical issues involved in the health care services requested by the provider, by reviewing and considering the requesting provider's recommendation, the member's medical or other clinical history, as applicable, and individual clinical circumstances. Artificial Intelligence (AI) will not be used to make *any* medical necessity decisions.

DEFINITIONS:
Artificial intelligence (AI) means an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments.

PROCEDURE:
If the organization uses artificial intelligence, algorithms, or other software tools for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, it will comply with and ensure all the following:

(A) The artificial intelligence, algorithm, or other software tool bases its determination on the following information, as applicable:

(i) A member's medical or other clinical history.
(ii) Individual clinical circumstances as presented by the requesting provider.
(iii) Other relevant clinical information contained in the members' medical or other clinical record.

(B) The artificial intelligence, algorithm, or other software tool does not base its determination solely on a group dataset.

(C) The artificial intelligence, algorithm, or other software tool's criteria and guidelines complies with this chapter, including, but not limited to, Section 1363.5 and applicable state and federal law.
(D) The artificial intelligence, algorithms, or other software tools do not supplant health care provider decision-making.
(E) The use of artificial intelligence, algorithms, or other software tools does not discriminate, directly or indirectly, against members in violation of state or federal law.
(F) The artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal Department of Health and Human Services.
(G) The artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the department pursuant to Section 1381 and by the State Department of Health Care Services pursuant to applicable state and federal law.
(H) Disclosures pertaining to the use and oversight of the artificial intelligence, algorithm, or other software tool are contained in the written policies and procedures, as required by subdivision (b).
(I) The artificial intelligence, algorithm, or other software tool's performance, use, and outcomes are periodically reviewed and revised to maximize accuracy and reliability.
(J) Member data is not used beyond its intended and stated purpose, consistent with the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) and the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), as applicable.
(K) The artificial intelligence, algorithms, or other software tools do not directly or indirectly cause harm to the member.

FORMS:
None

REFERENCE:
SB-1120 Health care coverage: Utilization review.

SUBJECT: Sub-delegation of UM and Oversight of MSO **Policy #:** UM47

DEPARTMENT: Administration

Effective Date: October 20, 2022
Last Revision Date:
Last Review Date: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure the MSO or UM sub-delegated entity is in compliance with the written delegation agreement of delegated activities.

POLICY:

If the IPA sub-delegates the Utilization Management process, a written delegation agreement will be completed listing all delegated activities and responsibilities for each party. The agreement must be approved by the health plans prior to implementation. The document will describe the remedies available to the IPA should the delegated entity not fulfill it's obligations. The agreement will be mutually agreed upon and must also be signed by both parties.

Annually the IPA Board UM QI Committees will review the MSO's compliance with the delegated activities. If in the IPA's review of the MSO's process any issues are identified, the MSO will implement Corrective Action.

Annual the IPA Board UM QI Committees will review the Memorandum of Understanding for Delegated Activities between the MSO and the IPA. Any updates needed throughout the year will be done in form of an amendment.

Annually the IPA Board UM QI Committees will review all Programs and Policies & Procedures for adoption. Any updates throughout the year will be presented to the IPA for review and approval prior to implementation.

Health Plan audit results will be reported by the MSO to the IPA Board UM QI Committees including any required corrective action plan.

PROCEDURE:

I. Audit results and any plans for corrective action are reported to the Board of Directors UM QI Committees upon receipt. An annual reporting of the Audit results will be presented for trending and any addition identification of opportunities for improvement.

II. For any sub-delegated arrangements in place for 12 months or longer:

1. The delegated entity will provide clinical performance to the IPA when requested.

2. IPA will annually evaluate the delegate's performance against NCQA standards for delegated activities.

3. If the IPA delegates the decision-making process, the IPA will perform an annual review of the UM denials against NCQA standards.

4. The IPA will semi-annually evaluate regular reports on delegated activity.

5. Based on the findings from the monitoring processes, for any corrective action plan issues or identification of opportunity for improvement, a follow up re-evaluation will be performed at least once in each of the past 2 years to ensure improvement.

6. Member Satisfaction with the delegated entities performance will be evaluated annually.

REFERENCES
NCQA UM13

SUBJECT: UM Information Integrity **Policy #:** UM 46

DEPARTMENT: Utilization Management

Effective Date: July 2025
Last Revision Date: April 2025
Last Review Date: April 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure controls are in place to identify inappropriate documentation and updates to Utilization Management (UM) denial receipt dates and decision notification dates. This policy addresses auditing and corrective action when UM Information integrity issues are identified.

DEFINITIONS:

Turnaround Times: The time it takes from receipt to completion of the authorization process.

- Start date: The date and time on which the request is received. If the provider faxes a request or enters an automated system, the start date is the date the fax sent by the provider or entered the automated system, not the date the UM staff entered the system.
- End date: The date and time at which the decision is made, initial and written notifications to the provider and member as well as include any turn-around time for extension based on sending timely extension notice.

Senior Level Employee: Supervisor, Manager, Director, and Vice President.

The groups will follow the required turnaround times for processing and notifications to members and providers according to the type of request and the line of business.

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

POLICY:

Utilization Management Information Integrity refers to maintaining and safeguarding information used in the utilization management denial decision process against inappropriate documentation and updates to:

- UM Requests from members or their authorized representatives
- UM request receipt date.
- Appropriate practitioner review.
- Use of board-certified consultants.
- Clinical information collected and reviewed.
- UM decision.
- UM decision notification date.
- UM denial notice.

The company has access levels assigned to an employee sign-in that restrict adds, changes and view only according to the employee's job function. For example, claims staff will have "view only" access to referrals. In addition, according to job function reports, access is also limited. As per IS policies, [See IS-127 & PROG.10], system access is disabled, or password removed for employees who leave the organization or be terminated by the organization.

When a referral is submitted through the system portal, the system locks the receipt date and time entered by the provider and cannot be changed by staff.

When a member and provider notification is generated electronically, the system tracks the date and time of generation. A copy of the generated notice is attached to the referral. At any time, when a second notification is generated due to a change needed and/or an additional notification is requested, the system will track that date and time, create a second attachment of the notices and all date fields cannot be altered.

Decisions made by the physician reviewers cannot be altered. If an error in decision was selected, the new decision can be selected, and the system maintains/tracks the date and time of the initial decision.

Any system issue/glitch identified with locking fields are immediately reported to the Chief Information Officer.

All incoming fax referral requests are received in the UM department fax server which generates a date and time stamp upon receipt and creates a permanent image. The image is placed into a queue and the image cannot be altered. Referrals received in this fashion require a manual entry. The date and time on the image are entered as the receipt date and time in the appropriate system fields. The image is attached to the referral entry.

Should this manual entry contain data entry errors, or typographical errors, the referral date and time can be changed by a designated senior level employee to correctly match the image received date and time. Any correction to referrals is tracked by the system on the backend logging all field changes.

When updates are made to UM information the UM department will enter a note identifying what information was updated and the reason for the update. The UM system will stamp the date and time of the update and identify the staff member who made the update.

The following documentation and updates are inappropriate:

- Falsifying UM dates (receipt date, UM decision date, notification date).
- Creating documents without performing the required activities.
- Fraudulently altering existing documents (clinical information, board certified consultant review, denial notices.
- Attributing review to someone who did not perform the activity (appropriate practitioner review)
- Updates to information by unauthorized individuals.

A report can be run that identifies all changes and updates made to a referral and will include but is not limited to original items and changes to information, day/time of change made, person who made changes. The report function access is limited to the designated monitoring staff.

Auditing of any changes to UM request receipt dates, denial decision notification dates and UM staff documentation to referrals is performed at a minimum annually or monthly, or quarterly if deemed necessary by the compliance officer with the standard look back period of the prior weeks, months/quarters depending on the

audit cadence. The auditing will be performed by a senior level employee outside of the UM Department who is educated on the referral authorization process. The report will be utilized to assess reasons for the changes and to ensure strict compliance with regulatory requirements. Each item reviewed will receive a level for the type of change(s) made; [i.e., Level 0 – manual entry change to date/time or documentation appropriate Level 1 – Error in data entry change - requiring additional follow up - no quality concern and Level 2 – Date/time or documentation change not appropriate, - Compliance Concern]. The report will be maintained to assess any patterns with staff and/or opportunities for process improvement. Identification/instance of non-compliance will be reported immediately to the Compliance Officer who has oversight of the UM integrity auditing process and will act on all findings and implement a corrective action plan and quarterly monitoring process until improvement is demonstrated. A re-audit will be conducted within 3-6 months of the annual audit to determine the effectiveness of the corrective action implemented.

Audit results will be maintained and reported to the health plans as required. A designated senior level employee outside of the UM department will conduct an annual qualitative analysis of inappropriate updates to UM documentation, denial receipt dates and notification dates identified in the audit to determine the cause. The report will include the titles of UM staff involved in the qualitative analysis and the cause of each finding. The report will be presented to UM leadership and the Compliance Officer. Occurrences of non-compliance or continued non-compliance identified by the annual audit can result in additional UM staff training, suspension up to termination based on the severity of the findings. The UM staff will complete annual training on UM Information Integrity that includes audit analysis, the process for documenting and reporting inappropriate documentation and updates, consequences for inappropriate documentation and updates, and how UM Information Integrity issues are reported to the Compliance officer.

A designated denial team will follow the turnaround time requirements for processing denials. All denial letters will be manually generated, and a denial checkoff sheet will be utilized to track all processing. The VP of Inpatient and Outpatient Services or designated Nurse Reviewer reviews for content, readability, use of guideline, documentation noting hierarchy followed, and accuracy of data on check off sheet. The denial packet will include the denial letter, proof of initial notification to providers and members. If errors are found or changes are needed, the Nurse Reviewer will not sign off on the denial until the corrections are made and the packet is presented for re-review. Errors may include but are not limited to misspellings, addressing parents of adult patients, incorrect addresses, incorrect providers noted and or incorrect guideline citation. Once the nurse has signed off, the letter is sent to the member, and a copy of the stamped envelope is attached to the denial packet. The denial packet is then attached to the referral in the system.

POLICY:

ICE TATs – Commercial, Medi-Cal, CMS Medicare/Medicare Advantage

NCQA UM 12 UM Information Integrity

SUBJECT: Whole Child Model Program - California Children's Services **Policy #:** UM45
DEPARTMENT: Utilization Management

Effective Date: April 1, 2019
Last Revision Date: February 17, 2020
Last Review: January 2026

SCOPE:

This policy applies to CalOptima Medi-Cal.

PURPOSE:

Effective no sooner than July 1, 2019, CalOptima shall assume responsibility for California Children's Services (CCS) for Members who eligible and transitioned into the Whole Child Model program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification, evaluation and referral of Members with CCS eligible condition. Health Networks shall assume responsibility for coordination of determination of CCS eligibility and authorization in conjunction with CalOptima and the local CCS agency for potential CCS eligible medical services. This includes but is not limited to, authorization activities, claims processing, case management and quality oversight.

To ensure that all members who have California Children's Services eligible medical conditions are appropriately identified and referred to local CCS paneled providers for treatment.

To ensure members with a CCS eligible condition also receive services not related to their CCS eligible condition in a timely manner.

To ensure that a coordinated effort of referring for CCS services occurs between the Primary Care Physician, the UM Department, Case Managers and CCS Coordinators, CCS Providers and facility, CCS Case Manager, the member's assigned Health Plan Case Manager, and the member and/or member's representative.

POLICY:

The Whole Child Model Program is open to members who are less than 21 years of age and a resident of Orange County California or is applying for residence, that have a physical limitation or disease that is covered under the CCS condition list.

Current and applicable California Children's Services Program Guidelines, CCS Numbered Letters and county CCS Program Information Notices must be considered when requesting coverage for Whole Child Model [WCM] program. As part of the WCM, CCS eligible members will receive Case Management [See Case Management Program and Policies & Procedures].

Identification of member eligible for CCS coverage may come from the Health Network's Medical Management Department, including but not limited to Concurrent Review Nurses, Case Managers, UM Coordinators and CCS Coordinators, the Primary Care Physician, Specialists, Member Services, Claims and other community partners.

CCS eligible conditions information is located at:

a) https://www.dhcs.ca.gov.services/ccs/Pages/medicaleligibility.aspx
b) https://www.dhcs.ca.gov/services/ccs/Docuemnts/CCSMedicalEligibility.pdf

Staff will be in-serviced annually on the general conditions that meet eligibility for CCS coverage. Staff will have knowledge and adequate training on the Whole Child Program and must be able to identify and refer members with potential CCS eligible conditions to the local CCS program for CCS medical eligibility determination. CCS Case Managers will have clinical experience with either the CCS population or with complex pediatric medical conditions.

Members with a qualifying diagnosis will be identified and coded as CCS, referred to CCS paneled providers for services and a request for determination is submitted to CalOptima within 24 hours of identification. CalOptima facilitates communication with the local CCS Agency for determination of CCS eligibility and participation in the WCM.

As part of Concurrent Review, identification will be made for members who may be eligible for High Risk Infant Follow Up Program [HRIF] following an NICU admission. Coordination of NICU admission will occur in conjunction with CalOptima and/or local CCS Agency to determine member eligibility and coverage. Members determined to be eligible will be referred to a Case Manager at time of discharge. Continuity of care support, including notification to the local CCS Agency will be provided to any neonate and child up to age of 3, who lose eligibility coverage for HRIF within 15 days.

The PCP is responsible for providing a complete baseline health assessment and diagnostic evaluations to confirm or rule out a potential CCS eligible condition. If CCS eligibility is established, the PCP remains responsible for providing primary care services to the member, in accordance with CalOptima Pediatric Preventive Services guidelines, and coordination of services to ensure continuity of care.

The parent or caregiver of a CCS-eligible member may request a specialist or clinic as a primary care provider A CCS specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of CCS-eligible conditions of the CCS child or youth.

If the IPA does not have an active contract in place or the location of the specialist office does not meet the members need or cultural needs, the UM Coordinator will work with Provider Services to locate a specialist. In some cases, the UM Coordinator and Provider Services may identify and refer to a provider within the broader CalOptima provider network.

For Members eligible with the WCM program, Health Network must allow access to Out-of-Network providers in order to obtain Medically Necessary Covered Services, if:

- The Member or CCS-paneled provider follows Health Network's authorization policies and procedure to obtain appropriate approvals prior to accessing an Out-of-Network Provider; and
- Health Network has no specialist that treats the CCS-eligible Condition within the network; or
- In-network providers are unable to meet timely access standards, as described in CalOptima Policy GG.1600: Access and Availability Standards.
- Health Network cannot deny out-of-network services based upon cost or location.

- Health Network shall ensure transportation is provided for Members obtaining Out-of-Network Covered Services in accordance with CalOptima Policy GG.1547: Maintenance and Transportation.

CCS services are covered only from the time the referral is submitted to CCS, except for emergency services or services provided after hours. Referrals for emergency or after-hours care for potential CCS eligible conditions will be submitted to CalOptima for coordination with local CCS agency the next business day and must include appropriate documentation justifying emergency or urgent care.

All CCS eligible case will be referred to Case Management for care coordination.

The CCS Coordinator will maintain an ongoing log of all cases. The expiration dates for the CCS SAR will be monitored in conjunction with the Case Management process to ensure no gap in coverage for any WCM member with further medical needs. Requests and reporting of initial determination and annual redeterminations will be coordinated with CalOptima.

CalOptima will be notified of members transitioning into the Whole Child Model Program who develop additional CCS eligible conditions separate from the conditions known at transition and authorization process will be followed.

The Primary Care Physician, Medical Director, Specialist, Members and/or their representative may request an appeal of any case that is denied by the Local CCS Agency. Members will be provided information on the Grievance, Appeals and State Fair Hearing process. CalOptima maintains responsibility for coordination of Grievances and Appeals.

The Case Manager will monitor member eligibility with Medi-Cal and proactively coordinate transition services for a WCM Member who loses Medi-Cal eligibility to the County CCS Program for ongoing health care and case management services.

DEFINITIONS:

California Children's Services (CCS) is a program that provides physical habilitation and rehabilitation for children with specific conditions. CCS sets forth the eligible specific conditions and guidelines for coverage of the condition. The goal is to obtain the medical and allied services necessary to achieve maximum physical and social function for children meeting these specific conditions. In most cases, the maximum age for eligibility is 21 years old.

Age- Out Transition and Planning: Process of identification and plan for members who will require long-term health care needs beginning at age 14 and again at ages 16, 17, 18, 20 and 20 and 8 months

Medical Therapy Unit [MTU]: Provides medically necessary physical and occupational therapy services for children with medically eligible physical disabilities at a medical therapy unit located on a public school campus. The MTU goals are the development of functional skills, independence and to improve the quality of life for both the child and their family.

Specialized and Customized Durable Medical Equipment: Wheelchairs [manual and power], wheelchair positioning systems and seating inserts, standers, gait trainers, walkers, adaptive strollers, shower/bath chairs and toileting equipment which meet all the following:

1. Is a uniquely constructed or substantially modified solely for use of the member;

2. Is made to order or adapted to meet the specified need of the member;
3. Is uniquely constructed, adapted or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

PROCEDURE:

Pre-Authorization Outpatient/Planned Services:

A. All referral requests initially screened by the UM Coordinator that appear to fall within the categories of medical eligibility for CCS will be coded as a potential CCS medically eligible case utilizing current and applicable California Children's Services Program Guidelines, CCS Numbered Letters and county CCS Program Information Notices.

B. Verification of CCS Paneled provider/facility will be determined and documented.

1. When request with a potential CCS eligible condition to a non-paneled CCS provider is received, designated staff will contact the PCP within 24 hours to verify if member's care can be transitioned to a CCS paneled provider.
2. If the IPA does not have an active contracted CCS paneled provider to meet the member's needs in a timely manner, the UM Coordinator will research the CalOptima CCS paneled provider list for identification of appropriate provider. If required, a Letter of Agreement will be initiated.

C. The referral will be processed through the usual UM Authorization process and will be reviewed by the Medical Director to determine need to refer case to CalOptima for CCS medical eligibility.

1. If the Medical Director determines the case does not meet CCS medical eligibility, the referral will be coded as a standard request and processed.

D. If the referral appears to meet potential CCS medical eligibility, within 24 hours or next work day the case will be coordinated with CalOptima and local CCS agency for CCS eligibility determination and acceptance in the Whole Child Program. Authorization should not be held pending CCS medical eligibility determination.

1. Documentation submitted for review, will include:

    a. A completed CCS program referral form
    b. Medical history with confirmation of medical condition and supporting medical information to confirm that a CCS eligible condition exists
    c. Description of services being requested
    d. Name of CCS paneled provider who will provide the requested services (if known)
    e. Name and telephone number of the referral source
    f. Completed CCS program application if available at the physician's office at the time of the referral

2. The CCS Coordinator may make daily / weekly calls to obtain a CCS Registry number and Service Authorization Request [SAR] number.

E. Communication of the final determination will be received come from CalOptima.

F. Notifications of final determination is sent to both the member and provider/facility.

1. If the determination is denied, the member and provider will be notified of their appeal rights.
2. The denial will be documented in the medical record and the code for CCS will be removed. The member will receive the standard notifications for approval of service where medically indicated under their Medi-Cal benefit.

G. The CCS Coordination will refer the case to Case Management.

Pre-Authorization for Specialized and Customized Durable Medical Equipment:

A. Request for Specialized and Customized DME may come from a provider or from the Medical Therapy Unit or Medical Therapy Program.

B. Members not participating in the Medical Therapy Unit [MTU] will be referred for a Home Assessment prior to approval for specialized and customized DME.

C. Payment will be at least equal to the applicable CCS FFS rates, as per regulation requires, unless otherwise agreed upon by the provider and CalOptima/ Health Network.

Concurrent Review:

A. As part of coordination for admissions, if a member is identified with a CCS eligible condition:

1. Verification of Facility and Provider's CCS paneled status will be determined, and case will be coded as CCS.

2. A request for determination is submitted to CalOptima within 24 hours of identification or next business day. CalOptima facilitates communication with the local CCS Agency for determination of CCS eligibility and participation in the WCM.

   a) Documentation submitted for determination will include a copy of the admission face sheet and current treatment plan with any available discharge plan needs from attending physician.

3. Members admitted to the Neonatal Intensive Unit may be coordinated with the High-Risk Infant Follow Up Program [HRIF].

B. Anticipated discharge needs will be referred to CCS paneled providers. Services that are not covered under the CCS condition will be coordinated and processed under the Medi-Cal benefit.

C. The Concurrent Review Nurse will refer the case to Case Management.

D. Communication of the final determination will be received come from CalOptima and attached to the medical record.

Retrospective Review:

A. Determination for CCS eligibility is performed on pre-authorization and concurrent services. If a case is identified on a retrospective basis, the case will be forwarded for determination of eligibility for on-going service needs.

B. Emergency services will be forwarded for determination on the next business day following notification.

Reporting of CCS activity:

A. Reporting of CCS activity will include, but is not limited to, according to CalOptima's Reporting Requirements:
    1. List of CCS paneled providers.
    2. Encounter activity
    3. Referral Activity
    4. Assessments of Care Coordination
    5. Continuity of Care Reports

FORMS:
Not applicable

REFERENCES:
Whole Child Model Program

SUBJECT: Palliative Care Services **Policy #:** UM44

DEPARTMENT: Utilization Management

Effective Date: January 1, 2018
Last Revision Date: February 21st, 2024
Last Review Date: February 2026

SCOPE:
This policy applies to the Medi-Cal line of business.

PURPOSE:
To ensure Members have effective and appropriate access to Palliative Care services through proactive identification, facilitating referrals and coordinating care with Palliative Care service providers.

POLICY:
The Utilization Management (UM), Concurrent Review (CCR) and Case Management staff shall coordinate Palliative Care services utilizing qualified providers, including but not limited to hospitals, long-term care facilities, community clinics, hospice agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in Palliative Care, and based on the setting and needs of the Member. If the service is a benefit of the member's health plan but the group is not delegated the request will be forwarded to the health plan.

The IPA shall provide medically necessary Palliative Care services to Members meeting all the following minimum eligibility requirements, including at least one (1) of the disease-specific eligibility criteria as described in number six (6) below:

1. The Member is likely to or has started to use the hospital or emergency department to manage his or her advanced disease (unanticipated decompensation and not including elective procedures); and

2. The Member has an advanced illness as outlined in number six (6) with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment; and

3. The Member's death within a year would not be unexpected based on clinical status; and

4. The Member has either received appropriate patient desired medical therapy or is a Member for whom Member-desired medical therapy is no longer effective. The Member is not in reversible decompensation; and

5. The Member, and if applicable, the Member's family/Member-designated support person agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based or outpatient disease management/palliative care prior to use of the emergency department, and
    b. Participate in Advance Care Planning discussions.

6. Disease-Specific Minimum Eligibility Criteria

    1. Congestive Heart Failure (CHF) with both:
        a. New York Heart Association (NYHA) heart failure classification III or higher or is hospitalized due to CHF as a primary diagnosis with no further invasive interventions planned; and
        b. Has an ejection fraction less than 30 percent (30%) for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD)
    a. Forced Expiratory Volume (FEV) less than 35 percent (35%) of predicted and twenty-four (24)-hour oxygen requirement of less than three (3) liters per minute; or
    b. Twenty-four (24)-hour oxygen requirement of greater than or equal to three (3) liters per minute.

3. Advanced cancer with both:
    a. Stage III or IV solid organ cancer, lymphoma or leukemia; and
    b. A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver disease with:
    a. Irreversible liver damage, serum albumin less than 3.0 and International Normalized Ration, (INR) greater than 1.3, and
    b. Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. Evidence of irreversible liver damage and has a Model for End Stage Liver Disease, (MELD) score of greater than 19.

If a member continues to meet the above minimum eligibility criteria, he or she may continue to access both Palliative Care and Curative Care until the condition improves, stabilizes, or results in death.

Palliative Care services shall include the following services coordinated by the Provider:

1. Advanced Care Planning, including documented discussions between a physician or other qualified healthcare professional and a Member, family member, or legally recognized decision-maker. Counseling that occurs during these discussions shall address, but not be limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST);

2. Palliative Care assessment and consultation, which may be provided at the same time as Advance Care Planning or in subsequent Member conversations to collect both routine medical data and additional personal information not regularly included in a medical history. During an initial and/or subsequent Palliative Care consultation or assessment, topics may include, but are not limited to:

    a. Treatment plans, including Palliative Care and Curative Care.
    b. Pain and medication side effects.
    c. Emotional and social challenges.
    d. Spiritual concerns.
    e. Member goals.
    f. Advance Directives, including POLST forms; and
    g. Legally-recognized decision maker.

Plan of care developed with the engagement of the Member and/or the Member's Authorized Representative. If a Member already has a plan of care, the Provider shall update the plan to reflect any changes resulting from the Palliative Care consultation or Advance Care Planning discussion. The Member's plan of care must include all authorized Palliative Care, including but not limited to pain and symptom management and Curative Care. The plan of care must not include services already received through another Medi-Cal-funded benefit program.
The Palliative Care team shall include a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the Member and the Member's family and are able to assist in identifying sources of pain and discomfort of the Member. This may include, but is not limited to, problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, and/or nausea. The Palliative Care team shall also address other issues such as medication services and allied health needs.

The Palliative Care team may include, but is not limited to, the Member's Primary Care Provider (PCP), a registered

nurse, licensed vocational nurse or nurse practitioner, and a social worker. Chaplain services may be part of the Palliative Care team.

The Palliative care team members shall provide all authorized Palliative Care services.

Care coordination provided by a member of the Palliative Care team, to ensure continuous assessment of the Member's needs and to implement the plan of care.

Pain and symptom management, utilizing prescription drugs, physical therapy and/or other Medically Necessary services to address a Member's pain and other symptoms. The Member's plan of care shall include all services authorized for pain and symptom management.

Mental health and medical social services shall be available to the Member to assist in minimizing the stress and psychological problems that may arise from a serious illness, related conditions, and the dying process. Counseling facilitated by the Palliative Care team may include, but is not limited to:

a. Psychotherapy.
b. Bereavement counseling.
c. Medical social services; and
d. Discharge planning, as appropriate.
e. Provision of medical social services shall not duplicate Specialty Mental Health Services provided by the Orange County Health Care Agency (HCA) and shall not change IPA's responsibilities for referring to and coordinating with the Orange County HCA.

Members will be periodically assessed for their condition or Palliative Care needs. Palliative Care may be discontinued if services are no longer medically necessary or reasonable.

A Member may receive Palliative Care concurrently with Curative Care and may elect to transition to Hospice Care if the Member meets the hospice eligibility criteria. A Member may not receive Palliative Care and Hospice Care concurrently, except as described below.

A Member under the age of twenty-one (21) may be eligible for Palliative Care and Hospice Care services concurrently with Curative Care through other existing programs such as Home and Community Based Services (HCBS) waiver known as Pediatric Palliative Care Program (PPC) or concurrent care under Section 3202 of the Affordable Care Act (ACA).

For members who were previously covered under the Pediatric Palliative Care Waiver Program under Medi-Cal Fee for Service and now transitioning into Medi-Cal Managed Care, the member, provider, or the member's representative may request continuity of care for out of network providers who provided Medi-Cal-covered PPC waiver services to the member that are also covered under EPSDT for up to 12 months.

The IPA shall be responsible for providing Hospice Care services for Terminally Ill Members as stated in the delegation agreement with the Plan.

The IPA shall be responsible for design, planning, referrals, and implementation of Palliative Care services for their Members, at a minimum, in accordance with SB 1004 (2014) and DHCS APL 17-015: Palliative Care and Medi-Cal Managed Care.

The IPA shall collect and submit reporting requirements which include but are not limited to enrollment, providers, utilization data and encounter data as required by the Plan.

DEFINITIONS:

Advance Care Planning**:** Documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally recognized decision maker.

Advance Directive: A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.

Curative Care: Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress.

Palliative Care: Patient and family centered care that optimizes quality of life by anticipating, preventing and treating suffering.

PROCEDURE:

Palliative Care services will be authorized when a member meets the minimum eligibility requirements without regard to the Member's age.

Members who are potentially eligible for Palliative Care services will be identified through various sources, including, but not limited to:

1. Prior Authorization referrals.
2. Concurrent review referrals.
3. Case management referrals.
4. Disease management referrals.
5. Provider referrals; and
6. Claims and encounter data.

Members who are eligible for Palliative Care services can be referred from both PCPs, as well as appropriate specialists including, but not limited to Oncologists, Hematologists, Pulmonologists and Cardiologists.
Palliative Care services will be provided within timely access standards in accordance with the Plan's policies.

Members shall be entitled to appeals and grievance procedures in accordance with the Plan's policies and or delegated functions.

FORMS:
None

REFERENCES:
Department of Health Care Services (DHCS) All Plan Letter 17-015: Palliative Care and Medi-Cal Managed Care.

SUBJECT: Appointment of Representative [AOR] **Policy #:** UM 43

DEPARTMENT: Utilization Management

Effective Date: October 2014
Last Revision Date: June 11th 2025,
Last Review Date: June 2026

SCOPE:

This policy applies to the Medicare and Medi-Cal lines of business..

PURPOSE:

To identify and ensure documentation of member appointed representatives.

POLICY:

Members may appoint and allow a representative to facilitate care or treatment decisions for a member who is incapable of doing so because of physical or mental limitations.

The following is a list of the types of individuals who could be appointed to act as a representative appointed by an enrollee:

- Family members of a beneficiary,
- Friends or neighbors of a beneficiary,
- Guardian holding Durable Power of attorney or healthcare proxy, or a person designated under a health care consent statute,
- Court appointed advocate or member of a beneficiary advocacy group,
- Member of a provider or supplier advocacy group,
- Attorneys; and
- Physicians or suppliers
- Executor of an estate

When verbally submitting grievances, initial determinations, and reconsiderations, when applicable, members cannot verbally appoint a representative and must submit a valid representative form. Members may appoint a representative by completing the form CMS-1696 Appointment of Representative and submitting it to the Case Management or Member Services Department. Both the members and their representatives must complete the form, sign, and date. The form will be valid for 1 year from the date the form contains the signatures of both the parties. A copy will be maintained in the member's electronic file. An appointed representative on behalf of the party may obtain appeals information, submit evidence, make statements about facts and law, and make any request, or give, or receive, any notice about appeal proceedings.

A valid Appointment must:

1. Be in writing and signed and dated by both party and individual agreeing to be the representative.
2. Provide a statement appointing the representative to act on behalf of the party.

3. Include a written explanation of the purpose and scope of the representation.

4. Contain both the member and appointment representative's name, phone number, and address.

5. Identify the beneficiary's Medicare number when the beneficiary is the part appointing a representative or identify the Medicare National Provider Identifier number of the provider or supplier that furnished the item or service when the provider or supplier is the party appointing the representative.

6. Include the appointed representative's professional statues or relationship to the party.

7. Be filed with the entity processing the party's initial determination or appeal.

No member information will be shared or coordinated with the representative until the form has been received. If a request is received from a member or member representative and there is no AOR on file, the member and the member representative, the practitioner or member will be notified in writing within 24 hours for expedited request and within 5 days for non-urgent request, notifying all parties that the coverage request, or appeal is not valid until documentation is provided.

For urgent expedited requests, reasonable efforts will be made to prevent any inappropriate delays. In the event that a form is not currently on file or has expired and the appointed representative has requested services to be authorized for a member, the staff will request and make reasonable efforts to obtain the appropriate documentation to verify that the Representative and enrollee have an on-going relationship, prior to review of the request. A decision will not be made until or unless such documentation is obtained. If the appropriate documentation is not received by the conclusion of the applicable timeframe, plus any applicable extension the request will be dismissed because the person or entity making the request is not permitted to request a coverage decision or appeal or is not a proper party.

For the Medi-Cal line of business, the IPA may accept a written authorization from an enrollee that complies with state Medicaid requirements, even if such an authorization does not contain every element described under Section 20.2 of The Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Written Notification will be mailed to the member and person asserting representative status and will include the following information.

1. Reason for the dismissal
2. The right to request that the organization vacate the dismissal action.
3. The right to request review of the dismissal.
4. How the invalid request can be cured and that the request will be processed if the member or representative submits a properly executed form.

CMS defines reasonable opportunity to submit the appropriate AOR form to be as follows:

1. Standard pre-service requests: 28 calendar days total [14 days review period plus 14-day extension]

2. Expedited pre-service request: 17 calendar days [72 hours plus 14-day extension]

3. Standard post-service request: 60 calendar days

After these timeframes, if the fully executed AOR form is not received, the request will be

dismissed/cancelled and both the member and their reported representative will receive notification.

Any request for filing a grievance will be directed to the member's health plan.

REFERENCES

Form CMS-1696 Appointment of Representative
42 CFR 405.910 Appointed Representatives
Medicare Appeals and Grievances Section 20.1 Representatives Filing on Behalf of Enrollees

SUBJECT: Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment [SABIRT] Policy # UM 42

DEPARTMENT: Utilization Management

Effective Date: July 2014
Last Revision Date: December 29, 2022
Last Review: January 2026

SCOPE:

This policy applies to all Medi-Cal lines of business.

PURPOSE:

To ensure primary care requirement to provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) to members ages 11 years and older, including pregnant women.

All members 18 years and older responding yes to Alcohol Screening questions in Staying Healthy Assessment are given an additional expanded alcohol screening questionnaire.

To reduce the risk Alcohol misuse plays in a wide range of health conditions such as hypertension; gastritis; liver disease, including cirrhosis; pancreatitis; certain types of cancer, such as breast and esophageal cancers; cognitive impairment; anxiety; and depression.

POLICY:

Medi-Cal providers are required to complete an initial health assessment, which includes the age-appropriate history, physical examination and health education behavioral health assessment. Although plans must provide one alcohol misuse screening per year, additional screenings must be provided when medically necessary. Medical necessity must be documented by the member's PCP.

As part of the EPSDT requirement, PCPs are contractually required to provide services as recommended by the American Academy of Pediatrics (AAP) Bright Futures initiative for all members under 21 years of age. The AAP develops guidance and recommendations for preventive care screenings and well-child visits for children and regularly publishes updated tools and resources for use by clinicians and state agencies. Per AAP/Bright Futures recommendations, tobacco, alcohol, and drug use screening and assessment with appropriate follow-up action as necessary should begin to occur at 11 years of age. In providing SABIRT services, PCPs must comply with all applicable laws and regulations relating to the privacy of 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.

PCPs are also contractually required to provide all preventive services for members who are 21 years of age or older consistent with USPSTF Grade A and B recommendations. The USPSTF assigned a Grade B recommendation for Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults, as of November 2018, and for Screening for Unhealthy Drug Use, as of June 2020. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. Additionally, the USPSTF recommends screening by

asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. PCPs are also contractually required to provide all preventive services for members who are 21 years of age or older consistent with USPSTF Grade A and B recommendations. The USPSTF assigned a Grade B recommendation for Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults, as of November 2018, and for Screening for Unhealthy Drug Use, as of June 2020. The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. Additionally, the USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

Effective January 1, 2014, the IPAs are responsible to cover and pay for an expanded alcohol screening for members 18 years and older who answer "yes" to the alcohol question in the Staying Health Assessment or at any time the provider identifies potential misuse of alcohol.

All members 18 and over who misuse alcohol will receive a counseling/screening in the primary care setting to impact risky drinking behavior, as well as potentially reduce injury or death as a result of such behavior.

Alcohol Use Disorder [AUD] is a mental health condition recognized by the Diagnostic and Statistical Manual of Mental Disorders (DSM), and as such, PCPs must provide mental health parity services for members screened and determined to have an AUD. Specifically, the Medicaid and Children's Health Insurance Program Managed Care Final Rule (CMS-2390-F)10 requires Medicaid Managed Care Organizations to provide coverage for certain benefits required under the Mental Health Parity and Addiction Equity Act of 2008, including Subpart K – Parity in Mental Health and Substance Use Disorder Benefits. As of October 2, 2017, MCPs are required to comply with the Mental Health Parity rule. The general parity requirement stipulates that financial requirements or treatment limitations for mental health benefits may not be more restrictive than the predominant financial requirements or treatment limitations applied to medical or surgical benefits

Each doctor's office is required to establish, implement, and ensure that at least one supervising licensed provider per clinic or practice, and one trained non-licensed staff has received the minimum four-hour SABIRT Training. Training Attestations are a one-time requirement.

SABIRT trainings must be completed by December 31, 2014. Provider Services will maintain a copy of the PCP office attestations of the SABIRT training. At any change in staffing, the PCPs office will ensure the newly assigned staff receives required training.

Licensed Providers

Primary care physicians (PCPs), physician assistants, nurse practitioners, and psychologists who provide SABIRT services or supervise a trained, unlicensed health care provider in the provision of SABIRT services are required to comply with the following training requirements, at a minimum:

- For clinics or practices, at least one supervising licensed provider must complete four hours of SABIRT training within 12 months after initiating SABIRT services
    - Beyond the first 12 months of providing SABIRT services, at least one supervising licensed provider per clinic or practice must have completed training

Though not required, it is recommended that:

- All rendering licensed providers take training in order to provide SABIRT services
- For providers practicing alone, the provider complete four hours of SABIRT training within 12 months after initiating SABIRT services

Trained, Unlicensed Providers
Trained, unlicensed providers, including, but not limited to, health educators, certified addiction counselors, health coaches, medical assistants, and trained, unlicensed behavioral assistants, are required to comply with the following training requirements, at a minimum, in order to provide SABIRT services:

- Be under the supervision of one of the following types of licensed providers only:
  - Licensed physician
  - Physician assistant
  - Nurse practitioner
  - Psychologist

- Prior to rendering SABIRT services, complete a minimum of 60 documented hours of professional experience, such as coursework, internship, practicum, education, or professional work, within their respective fields. This experience should include a minimum of four hours of training directly related to SABIRT services, such as motivational interviewing

- Prior to rendering SABIRT services, complete a minimum of 30 documented hours of face-to-face client contact within their respective fields, in addition to the 60 hours of clinical professional experience described above. These contact hours may include internships, on-the-job training, or professional experience and SABIRT services training.

Behavioral counseling interventions for alcohol misuse vary in their specific components, administration, length, and number of interactions, but may include cognitive behavioral strategies, such as action plans, drinking diaries, stress management, or problem solving. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling.

The group must offer at least one, but may offer up to a maximum of three, behavioral counseling interventions for alcohol misuse per year. Additional behavioral counseling interventions must be authorized when medically necessary; however, medical necessity must be documented by the member's PCP.

PCPs must maintain documentation in medical records of the SHA and the expanded screening. When a member transfers to another PCP, the receiving PCP must obtain prior records. If no documentation is found, the PCP must provide and document this service.

Members meeting criteria will be referred to the alcohol and drug program in the county.

DEFINITION:

Alcohol Use Disorder: AUD is a chronic relapsing brain disease characterized by compulsive alcohol use, loss of control over alcohol intake, and a negative emotional state when not using.

Alcohol Misuse:

The United States Preventive Services Task Force uses the term "alcohol misuse" to define a spectrum of behaviors, including risky or hazardous alcohol use (e.g., harmful alcohol use and alcohol abuse or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion quantity of alcohol, resulting in increased risk for adverse health consequences (e.g., the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the U.S. Department of Agriculture define "risky use" as consuming more than four drinks on any day or fourteen drinks per week for men, or more than three

drinks on any day or seven drinks per week for women (as well as any level of consumption under certain circumstances).

The Centers for Disease Control and Prevention (CDC) Alcohol Team uses the following definitions of alcohol misuse:

Alcohol misuse

- For women, more than 1 drink per day on average
- For men, more than 2 drinks per day on average

Binge drinking

- For women, 4 or more drinks during a single occasion
- For men, 5 or more drinks during a single occasion

Excessive drinking includes heavy drinking, binge drinking or both

Alcohol misuse is a pattern of drinking that results in harm to one's health, interpersonal relationships or ability to work

Alcohol dependence, also known as alcohol addiction and alcoholism, is a chronic disease and is associated with experiencing withdrawal symptoms, loss of control, or alcohol tolerance.

Unhealthy Alcohol Use: The USPSTF uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to alcohol use disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for health consequences, but not meeting criteria for AUD.

Heavy Use: The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "heavy use" as exceeding the recommended limits of 4 drinks per day or 14 drinks per week for adult men or 3 drinks per day or 7 drinks per week for adult women.

Unhealthy Drug Use: is defined as the use of illegally obtained substances, excluding alcohol and tobacco products, or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual.

PROCEDURE:

A. Annually the group will educate Primary Care Physicians on the SABIRT requirements. Although plans must provide one alcohol misuse screening per year, additional screenings must be provided when medically necessary.

B. Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Validated screening tools include, but are not limited to:

• Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)

• Tobacco Alcohol, Prescription medication and other Substances (TAPS)

• National Institute on Drug Abuse (NIDA) Quick Screen for adults

- The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening

• Drug Abuse Screening Test (DAST-10)

• Alcohol Use Disorders Identification Test (AUDIT-C)

• Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents

• Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents

• Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

C. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

• NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
• Drug Abuse Screening Test (DAST-20)
• Alcohol Use Disorders Identification Test (AUDIT)

D. In addition to the above, any member 18 years and older who responded "yes" to the alcohol screening questions on the Staying Healthy Assessments/IEHBA-SHA forms will receive an expanded, validated alcohol screening assessment. Based on results, members may be counseled in office or referred out for additional services and treatment.

a. Members are allowed one expanded screening using a validated screening tool, a year, unless medical necessity dictates otherwise.
b. If a member transitions between IPAs and/or PCPs, the PCP must obtain the member's prior records if the member states they have already received the expanded evaluation.
c. For members referred for Brief Intervention, they must be allowed at least three brief intervention sessions per year. Brief Interventions typically include one to three sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities.
d. PCPs will refer members meeting criteria, or whose diagnosis is uncertain, to the alcohol and drug program if the county.

E. <u>Brief Interventions and Referral to Treatment</u>

1. For recipients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services.

2. Brief interventions must include the following:

a. Providing feedback to the patient regarding screening and assessment results• Discussing negative consequences that have occurred and the overall severity of the problem;
b. Supporting the patient in making behavioral changes; and
c. Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

3. PCPs must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the PCP must follow up with the member to understand barriers and make adjustments to the referrals if warranted. PCP should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand off to necessary treatment.

4. Documentation Requirements Member medical records must include the following:

    a. The service provided (e.g., screen and brief intervention);
    b. The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record);
    c. The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and
    d. If and where a referral to an AUD or SUD program was made.

F. After an initial screening by the PCP office, members will be given a follow up appointment within 14 days for follow up.

G. Providers will bill with code H0049 or H0050.

H. Where required, a quarterly evaluation of SABIRT activity will be reported to the health plans via their required reporting template.

FORMS:
All Plan Letter 18-014 (Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care Supersedes All Plan letter 17-016.

This APL was formerly named: “Screening, Brief Intervention and Referral to Treatment for Misuse of Alcohol”. This APL aligns with the April 2018 updates to the Preventive Services Medi-Cal Provider Manual (2) and supersedes APL 17-016.

SUBJECT: Breastfeeding Promotion Policy # UM 41
DEPARTMENT: Utilization Management

Effective Date: June 2014
Last Revision Date:
Last Review: January 2026

SCOPE:

This policy applies to all Medi-Cal lines of business

PURPOSE:

To ensure that a pregnant member receives breastfeeding information and services.

POLICY:

Breastfeeding is recognized as the preferred method of feeding for infants as recommended by the American Academy for Pediatrics, American College of Obstetrics and Gynecology, National Healthy Mothers Healthy Babies Coalition and the American Public Health Association.

The OB/Gyn's for the Medical Group will provide prenatal and postnatal breastfeeding education, refer to Perinatal Support Services, and refer for counseling when requested. Referrals are to be documented in the member's medical record.

Education materials will be received from the Health Plans and be culturally appropriate, written in 5th grade education level or below within the various threshold languages, are not permitted to contain any logo or be promotion from a baby formula manufacturer and must not contain any negative or contradictory information regarding breastfeeding.

The education materials must contain the health and economic advantages of breastfeeding, maternal and infant nutrition, lactation management and commonly perceived barriers to breastfeeding.

Lactation Management Aid to members may include lactation counseling and/or breast pump, breast pump kits. Electronic breast pumps are covered if:

1. The infant is unable to nurse due to prematurity, respiratory or cardiac problems affecting endurance , or other medical disorder;
2. The infant experiences problems with latching on to the Member's breast;
3. The member or infant is hospitalized;
4. The member is Mother to multiples;
5. The member is on medication that contraindicates breastfeeding;
6. The member experiences problems with relactation; or
7. The member is returning to work or school and has difficulty maintaining milk supply with a manual breast pump.

Ongoing postnatal support to a breastfeeding member may include referrals for health education, counseling and the provisions of medically necessary interventions.

If a baby cannot tolerate any form of formula or has a medical contraindication to the use of all formula types, a referral for human milk may be coordinated with Mother's Milk Bank.

DEFINITION:

Women, Infant and Children Supplemental Food Program (WIC): A federal program that provides nutritional education and vouchers to purchase specific foods to eligible women and their infants and small children. Food vouchers offered include milk, eggs, cereal, juice, iron-fortified formula and infant cereals.

PROCEDURE:

A. At the time of the first prenatal visit/initial prenatal visit:

    a. A nutritional assessment will be completed and recommendations specific to the member's individual dietary needs will be made to the member,

    b. Documentation of discussions regarding Importance of Breastfeeding will be maintained in the member's record.

B. Members will be referred to WIC for breastfeeding promotion, education and counseling and documentation of referral will be kept in the member's medical record.
C. Referrals for breast pumps, education, lactation counseling, etc., will be processed according to UM4 Referral Authorization process.

FORMS:

WIC Referral Form

REFERENCES:

Not applicable

SUBJECT: Access to Transgender Service **Policy #:** UM40

DEPARTMENT: Utilization Management

Effective Date: April 7, 2014
Last Revision Date: July 7th,
Last Review: 2023
January 2026

SCOPE:

This policy applies to Medi-Cal lines of business.

PURPOSE:

To ensure access to transgender services for Medi-Cal beneficiaries.

DEFINITION:

Transgender Services – refers to the treatment of "gender identity disorder", which may include psychotherapy, continuous hormonal therapy, laboratory testing to monitor hormone therapy and gender reassignment surgery that is not cosmetic in nature.

Medical Necessity - refers to services which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain through diagnosis and treatment of disease, illness or injury.

Reconstructive Surgery – is surgery performed to correct or repair abnormal structures of the body to create a normal appearance to the extent possible. In the case of transgendered beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.

Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body to improve appearance. Medi-Cal does not cover cosmetic surgery.

POLICY:

The group shall not discriminate against transgendered persons.

Treatment for Gender Dysphoria is a covered Medi-Cal benefit when Medical Necessity has been demonstrated or meets the definition of reconstructive surgery.

The determination of whether a service requested by a transgender beneficiary is medically necessary and/or constitutes reconstructive surgery must be made by a qualified licensed mental health professional and the treating surgeon in collaboration with the beneficiary's Primary Care Provider.

The group shall not deny access to transgender services. Medi-Cal providers must determine medical necessity of each claim on a case-by-case basis in order to determine if the requested service is covered by Medi-Cal.

The group shall not categorically limit a service or the frequency of services available to a transgender beneficiary. The group must timely provide all medically necessary and/or reconstructive surgery that are

otherwise available to non-transgender beneficiaries. The group may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive determinations and/or apply appropriate utilization management criteria that are non-discriminatory.

If a service is appropriately denied on the basis that the service is not medically necessary, not considered reconstructive surgery or that the service does not meet utilization management criteria, the decision is subject to review through the appeal and grievance process, the State Fair Hearing process of the DMHC Independent Medical Review process.

The group will utilize the criteria for medical necessity of transgender services based on the most current Standards of Care for the Health of Transsexual, Transgender and Gender nonconforming people" published by the World Professional Association for Transgender Health [WPATH] found at:

http://www.wpath.org/publications_standards.cfm

When issuing a Notice of Action letter (NOA) for clinical reasons not meeting medical necessity, the group will use language that supports the denial both on the basis of not medically necessary to treat gender dysphoria and does not satisfy the criteria of the reconstructive surgery statute.

Nationally recognized medical experts in the field of transgender health care have identified the following care services in treating gender dysphoria: Behavioral Health; Psychotherapy; Hormone Therapy and a variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender.

PROCEDURE:

1. All requests for transgender services will be evaluated using the Standards of Care found in Standards of Care - WPATH World Professional Association for Transgender Health.

2. Member's requiring referrals for basic psychotherapy will be coordinated through the member's plan according to responsible party and referral process.

REFERENCES:

All Plan letter 20-18

Health and Safety Code Section (§)1365.5; Title 42 United States Code § 18116; 45 CFR §§ 92.206, 92.207; 45 CFR § 156.125 (b)) DHCS APL 16-013

SUBJECT: Cancelled/Withdrawal Authorizations **Policy #**UM39

DEPARTMENT: Utilization Management

Effective Date: May 28, 2013
Last Revision Date: December 30th 2024
Last Review: January 2026

SCOPE:
This policy applies to all lines of business.

PURPOSE:
To ensure compliance with the Referral Cancellation process.

POLICY:
Referral cancellations must be tracked, monitored, reviewed and reported so that there is no interruption, delay in patient care, or results in under-utilization.

The party that submits a request for an initial determination may withdraw the request in writing at any time before the decision is issued.

PROCEDURE:

1. If there is a decision to cancel a utilization request, the UM Coordination will not cancel and authorization unless there is:
    a) No interruption in patient care
    b) No delay in patient care
    c) Does not result in under-utilization.

2. Examples of cancelled requests may include the following:
    a) Already approved authorization present in the system
    b) Expired referral request
    c) The member terminated eligibility.
    d) Duplicate requests not received on the same day.
    e) Member requests the authorization to be cancelled.

3. In the event that the referring or referred to provider contacts the provider group requesting additions and/or changes in diagnosis and/or procedure codes the original referral request may not be cancelled but will be withdrawn and notes will direct to the new referral.

4. Requesting practitioners will be notified of the cancelled request either verbally or by written notification.

5. Cancelled referral requests are tracked in the system and monitored as part of utilization activity reporting.

6. Cancelled referral request reports are reviewed at committee as part of utilization activity review.

Withdrawals of Initial Determination Request:

A request for an initial determination can be withdrawn at any time before the decision is made. The request to withdraw the initial determination must come from the party who requested the initial determination. If a request to withdraw the initial determination is filed, the request will be dismissed. The request to withdraw may be either written or verbal. For verbal withdrawal request the coordinator will clearly document in the system the date and the reason why the party chose not to proceed with the initial determination procedures.

Dismissals
Initial determination requests will be dismissed under any of the following circumstances:

1. The individual or entity making the request is not permitted to request an initial determination under applicable regulation.
2. The organization determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). A valid request includes sufficient information to identify the member to allow adjudication of the request (or at a minimum, make contact with the member to clarify the request) including a full name or member ID number or at least one means of contact (e.g., address, telephone number, or email.
3. The enrollee dies while the request is pending, and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interests mean having financial liability for the item(s) or service(s) underlying the coverage request.
4. When the individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the organization.

When the dismissal is due to timely withdrawal request, the initial determination will be dismissed.

Dismissal Notice:
A written dismissal notice will be mailed to the parties within the applicable adjudication timeframe in accordance with section 40.15.1.

The dismissal notice will include all the following:

1. The reason for the dismissal
2. The right to request that the organization vacate the dismissal action; and
3. The right to request review of the dismissal.

Dismissal Binding Unless Modified, Reversed or Vacated

The dismissal of an initial determination request is binding unless it is modified or reversed upon appeal or the dismissal is vacated for good cause.

Requests to Vacate Dismissal of an Initial Determination Request

The IPA may vacate its own dismissal if good cause is established within 6 months of the date of the notice of the dismissal. If a party submits a request to vacate a dismissal of an initial determination request and the request contains sufficient evidence or other documentation that supports a finding of good cause for vacating, the IPA makes a favorable good cause determination.

Once the IPA makes a favorable good cause determination, it vacates its prior dismissal action and performs an initial determination consistent with the Medicare processing timeframes. Where a finding for good cause is made, the IPA will document the reason for that finding in the medical record.

If the IPA does not find good cause to vacate the dismissal, the dismissal remains in effect. The IPA will issue a letter (not a dismissal notice) explaining that good cause has not been established and the dismissal cannot be vacated. The IPA will explain in clear language why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

REFERENCES: NCQA UM 4.F.3
Medicare Part C&D Enrollee Grievance, Organization/Determinations, and Appeals Section 40.14
Medicare Part C&D Enrollee Grievance, Organization/Determinations, and Appeals Section 40.14-15; CFR § 422.568.
Medicare Part C&D Enrollee Grievances, Organization/Determinations, and Appeals Section 40.15

SUBJECT: Applied Behavioral Analysis [ABA] **Policy #:** UM38

DEPARTMENT: Utilization Management

Effective Date: May 1, 2013
Last Revision Date: December 14th, 2023,
Last Review: January 2026

SCOPE:
This policy applies to Commercial and Medi-Cal lines of Business.

PURPOSE:
To ensure Commercial and Medi-Cal members requiring an Applied Behavioral Analysis are not denied services.

POLICY:

Effective January 2012 for Commercial members and effective September 2014 for Medi-Cal members requiring behavioral analysis for Autism Spectrum Disorders will be referred to their plan's contracted Behavioral Health Providers.

ASD specific screenings will occur at age 18 months and 24 months. These screenings may include the M-Chat and M-Chat-R forms which can be obtained from http://mchatscreen.com.

BHT services are a Medi-Cal covered benefit for members under 21 years of age when medically necessary, based upon the recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of autism spectrum disorder (ASD). BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training peering training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

Member must meet the following criteria to received BHT (Behavioral Health Treatment):

- Be under 21 years of age.
- Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence based BHT services are medically necessary.
- Be medically stable.
- Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or immediate care facility for persons with intellectual disabilities [ICF/ID].

BHT covered services must:

1. Be medically necessary and covered under Medi-Cal.
2. Be provided and supervised in accordance with an approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements.
3. Be provided by a Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional who meets the Medi-Cal requirements.

4. The group will offer members newly enrolled in Medi-cal managed care continued access to out of network providers (continuity of care) for up to 12 months, in accordance with APL 23-022.

Medi-Cal members must be informed of available Early Periodic Screening Diagnostic and Treatment [EPSDT] services are available for members. All Children must receive EPSDT screening to identify health and development issues. When screening indicates a need for further treatment child is referred to a Pediatric MD or Developmental Pediatric MD for further assessment.

The medical group will not issue a denial letter but will issue an Informational Letter to Member and/or Provider/Physician to direct the member for these services.

DEFINITIONS:

ASDs: Autism Spectrum Disorders, including but not limited to Asperger's syndrome, Pervasive Development disorder, Autistic disorder, Rett Syndrome and Childhood Disintegrative Disorder.

Behavioral Health Treatment [BHT]: BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement or through prompting to teach each step of targeted behavior. BHT services are designed to be delivered primarily to the home and in other community settings.

Medically Necessary: State and Federal law define a service as medically necessary if the service is necessary to correct or "ameliorate" defects and physical and/or mental illnesses and conditions. The common definition of ameliorate is to "make more tolerable."

PROCEDURE:

1. Upon receipt of a request for an Applied Behavioral Analysis/Behavioral Health Treatment for members with Autism Spectrum Disorders, an Informational Letter to Members and/or Provider/Physician will be completed with directions of where the member needs to go to see these services.

2. No IPA denial letter will be issued.

3. UM Staff will follow the member's Health Plan protocol using forms or contact numbers required to refer the member to the appropriate location for services.

References:
APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for members under the age of 21.
Health & Safety Code §1374.73
Behavioral Health Treatment (BHT) FAQ (ca.gov)

SUBJECT: Re-Opening Organization Determinations **Policy #:** UM36
DEPARTMENT: Utilization Management

Effective Date: December 2012
Last Revision Date: July 7th, 2023
Last Review: January 2026

SCOPE:

This policy applies to Medicare and Medicare Advantage.

PURPOSE:

To define the re-opening process for adverse determinations of initial service denials as an alternative to the standard appeals process.

POLICY:

Requests for re-opening of adverse determination, will be handled in the following manner under the following circumstances:

1) Following an adverse determination, if additional information or new and material evidence is received before the 60-calendar day timeframe to file Reconsideration has expired, the receipt of the additional information must be handled as a request for Reconsideration, unless there is a Clerical Error.

2) If additional written documentation/information is received after the 60-calendar day timeframe to file a Reconsideration has expired, the receipt of the additional information may be handled as a Reopening for any reason (i.e., Clerical Error, New and Material Evidence, Other), unless there is an active appeal pending.

Requests for re-opening must be in writing and the specific reason for re-opening must be clearly stated.

- Members may request verbally or in writing.
- Faxed requests are considered acceptable.
- A statement of dissatisfaction is not grounds for reopening.
- Peer to Peer calls cannot be considered a formal request for reopening.
- CMS policy changes are not a reason for requesting a reopening.
- In some cases, the Health Plan may be advising the group of the need to "re-open".

Re-openings may be initiated for one of the following reasons.

- HealthPlan revises the organization determination or reconsideration.
- Independent Review Entity (IRE) revised the reconsideration determination.
- Administrative Law Judge (ALJ) or attorney adjudicator revises his or her decision.
- The Council revised the ALJ or attorney adjudicator decision or its review decision.

A re-opening cannot be processed if there is already an appeal in process [except for in the case of clerical errors].

Re-Opening Timeframes:

A request for re-opening can be made within one year of the initial denial for any reason and within four years for good cause. Good cause is defined as new material evidence that was not available or known at the time of the original denial decision or the evidence in making the original denial decision was in error.

The timeframe for making reopening decisions is 30 days from the date of the written request for Standard requests and no later than 72 hours from the date of the written request for those cases requested as Expedited or urgent.

DEFINITIONS:

Adverse Determination: Denial of service.

Clerical Errors: Includes human and mechanical errors on the party or the group.

New and Material Evidence: Documentation that was not previously available and considered during the decision-making process. This includes but is not limited to additional tests and/or medical records not provided during the initial review.

Reconsideration: Reconsideration is considered an Appeal, which the group may or may not be delegated responsibility for processing. When not delegated, the group will forward/direct to the health plan.

PROCEDURE:

1. Upon receipt of request for re-opening of a referral:

    a) The request with supporting documentation or explanation of clerical error will be sent to a Physician Reviewer for final review and determination.

        - If the Physician Reviewer receives a request for re-opening and disagrees that the issue is a clerical error, the re-opening will be dismissed, and the party will be advised of any appeal rights, provided the time frame to request an appeal on the original denial has not expired.

        - If the Physician Reviewer still feels there is insufficient information to approve the procedure, the case will then be denied, and the party will be advised of any appeal rights, provided the time frame to request an appeal.

        - If the Physician Reviewer feels after all review that the case should be approved, the system will be updated with the new decision type "Re-Opened/Approved" and approval letters will be processed according to the usual authorization process.

        - Notification of decisions will be sent in an envelope marked "Important plan information".

    b) If the Member verbally requests a re-opening, the member will be asked if they filed an appeal with the health plan and if appealed, will be warm transferred to the health plan.

2. If in the documentation received, it appears the Provider or Member's reason for reconsideration is related to dissatisfaction, the party will be advised to contact the Health Plan to file an appeal.

3. In the case of a peer-to-peer conversation, the requesting party will be directed to put their request for re-opening in writing prior to any re-opening in the system.

4. The UM Coordinator must log in the request for re-opening. When required this information will be forwarded to the Health Plan monthly.

References:
Part C&D Enrollee Grievance, Organization/Determinations, and Appeals Guidance 08.2022, Section 10.3.2; 80.1., 80.2, 80.3.1, 80.3.2, 80.4, 80.5.

SUBJECT: Nutrition Products **Policy #:** UM35
DEPARTMENT: Utilization Management

Effective Date: August 2009
Last Revision Date:
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define the outpatient referral process for Nutrition Products.

POLICY:

In some cases, the health plan may maintain the responsibility for review, approval and coordination of nutritional products.

For when review and coordination of Nutritional Products has been delegated to the Medical Group, all requests for Nutritional Products will be reviewed for medical necessity prior to dispensing. Consideration will be given to the urgency of the member's need.

A prior authorization request for Nutritional Products will be submitted by the Primary Care Provider to the UM Department with the following information:

1) Member's diagnosis and indication for Nutritional Product
2) The method of administration of the Nutritional Product
3) Members current weight and height
4) For children, their growth chart, if available
5) Treatment Plan with estimated length of nutritional need and goals
6) Plans for surgical intervention, if indicated
7) Quantity of product required per day

Enteral Nutrition Products may be approved for members 21 years of age or older with a medically diagnosed condition that precludes the full use of regular food when such Enteral Nutrition Products is administered orally or enterally by feeding tube and when the member has a permanent nonfunctional disease of the structures that normally allow food to reach the small bowel, or disease of the small bowel that impairs digestion and absorption of an oral diet. This may include but is not limited to members with:

1) Feeding tubes;
2) Inherited metabolic disorders including but not limited to, disorders of carbohydrate, lipid, vitamin, mineral or amino acid and nitrogen metabolism; or
3) Enteral products are sole source of nutrition and member can only consume liquids and a feeding tube is not indicated.

For member under 21 years of age, consideration will be given to whether service is covered by CCS as part of a CCS eligible condition.

Enteral Nutrition Products may be approved for members under 21 years of age with a medical condition that prohibits the full use of regular foods. This may include but is not limited to members with:

1) Feeding tubes;
2) A physical, physiologic or pathologic condition resulting in inadequate nutrition;
3) A condition resulting in impairment of oral intake affecting normal development and growth;
4) Enteral products are sole source of nutrition;
5) Diagnosis of an inherited metabolic disorder such as but not limited to disorders of carbohydrate, lipid, vitamin, mineral, or amino acid and nitrogen metabolism.
6) Nutritional requirements cannot be met with the full use of regular foods and the member is either below the 25th percentile for weight and age growth or below the 10th percentile for the Body Mass Index (BMI).

Total Parenteral Nutrition (TPN) may be approved for a Member under the following circumstance:

1) The member has permanent pathology of the gastrointestinal tract which does not allow absorption of sufficient nutrients to maintain weight and strength, including but not limited to:

    a) massive small bowel resection resulting in severe nutritional deficiency;
    b) prolonged surgical ileus; or
    c) malignancy of the gastrointestinal tract

2) The member has temporary pathology of the gastrointestinal tract which does not allow absorption of sufficient nutrients to maintain weight and strength for more than seven days, including but not limited to:

    a) Severe pancreatitis;
    b) Surgery of the gastrointestinal tract;
    c) Anorexia nervosa with severe nutritional deficiency; or
    d) Intractable vomiting or diarrhea

Cases requiring ongoing Enteral Nutrition will be referred to Case Management. The Case Manager will coordinate with the Primary Care Physician, ordering provider and member to ensure no interruption in service. Where necessary, the Case Manager will coordinate with local public health agencies or community agencies to assess social and environmental conditions relating to Failure to Thrive.

Physicians shall not refer members requiring therapeutic enteral formulas to WIC.

For newly eligible members currently receiving Enteral Nutrition the medical group will follow the Continuity of Care policy to ensure no interruption in service.

DEFINITIONS:

Enteral Nutrition - the delivery of nutrients in liquid form directly into the stomach, duodenum, or jejunum.

Parenteral Nutrition - administration of nutriment intravenously.

Total Parenteral Nutrition (TPN) - intravenous administration, via a central venous catheter, of the total nutrient requirements of a patient with gastrointestinal dysfunction.

WIC: Women, Infant and Children's Program

PROCEDURE:

1. Requests for Nutritional Products, when delegated, will be requested by the PCP to the UM or Case Management Department and processed according to the urgency of the request.
    - Urgent requests will be processed within 24 hours
    - Emergent requests can be made by telephone
    - Standard Non-urgent requests received directly from the Pharmacy will be forwarded to the Primary Care Physician for authorization processing.

2. In order to process the prior authorization request for Nutritional Products, the following information must be clearly communicated:

    - Member's diagnosis and indication for Nutritional Product
    - The method of administration of the Nutritional Product
    - Members current weight and height
    - For children, their growth chart, if available
    - Treatment Plan with estimated length of nutritional need and goals
    - Plans for surgical intervention, if indicated
    - Quantity of product required per day

3. The Medical Director will review all request for nutritional products and determine medical necessity. Any denial of service will be processed in accordance with the Service Denial Process, under direction of the Medical Director.

4. The authorization will clearly state the number of products to be dispensed on a monthly basis and the length of the authorization in consideration of the treatment plan but will not exceed 120 days.

5. The case will be referred to Case Management for monitoring and assistance with potential follow up nutritional product coordination.

6. The pharmacy or supplier is responsible to ensure the member remains eligible with their health plan and the contracted IPA.

SUBJECT: Medicare Appeals Process **Policy #:** UM34
DEPARTMENT: Utilization Management

Effective Date: July 2009
Last Revision Date: June 10th, 2024
Last Review: June 2026

SCOPE:

This policy applies to Medicare lines of business.

PURPOSE:

To outline the policy and procedure for a reconsideration of a decision to discontinue services.

POLICY:

For Medicare Members who are receiving services within a Skilled Nursing Facility [SNF], Home Health Agency [HHA] or Comprehensive Outpatient Rehabilitation Facility [CORF] where discharge is planned or determination is made that services are no longer medically necessary; the Member will receive written notification [NOMNC - Notice of Medicare Non-Coverage] no later than 2 calendar days or 2 visits prior to the proposed termination of services. [This process does not apply to SNF Exhaustion of Benefits (100-day limit).]

The NOMNC will include member name, delivery date, date that coverage of services ends, and Quality Improvement Organization (QIO) contact information according to CMS requirements. The patient must be able to understand the purpose and contents of the notice in order to sign/date and must understand that they have the right to appeal the decision.

The NOMNC may be delivered earlier if the date that coverage will end is known. If an expected length of stay or service is 2 days or less, notice will be given upon admission.

Authorized representatives of incompetent members may be notified by telephone if personal delivery is not immediately available. Telephone contact with the representative must convey the notice contents. Conversation must be documented in the member's record. The date of the conversation is the date of receipt of the notice. Confirm telephone contact with written notification mailed the same day. If telephone contact is not possible, the written notice to authorized representative must be sent via certified mail, return receipt requested.

The date that someone at the representatives address signs (or refuses to sign) the receipt is the date of receipt. A dated copy of the notice will be stored in the member's medical record. When notices are returned by the post office with no indication of a refusal date, then the members' liability starts on the second working day after the provider's mailing date.

The following are exceptions to expedited review and NOMNC should not be delivered:

- When the member never received Medicare covered care in one of the covered settings
- When services are being reduced
- When beneficiaries are moving to a higher level of care

- When beneficiaries exhaust their benefits
- When beneficiaries end care on their own initiative
- When a beneficiary transfers to another provider at the same level of care
- When a provider discontinues care for business reasons

Member or their Representative have the right to appeal to the QIO. An Appeal of discontinued services can be requested by a member, member's family or a physician via verbal request or written request.

Upon notification by the QIO that a member or authorized representative has requested an appeal, a DENC notification will be sent to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

When requested by the QIO, the IPA will forward medical records with the DENC notification.

DEFINITIONS:

ALJ – Administrative Law Judge

Appeal – Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services.

CORF – Comprehensive Outpatient Rehabilitation Facility - must provide coordinated outpatient diagnostic, therapeutic, and restorative services, at a single fixed location, to outpatients for the rehabilitation of injured, disabled, or sick individuals. Physical therapy, occupational therapy and speech-language pathology services may be provided in an off-site location.

DENC - Detailed Explanation of Non-Coverage Notification – Explanation in detail of why the service is no longer covered. This includes a description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee ma obtain a copy of the Medicare policy from the Medicare health plan; Any applicable Medicare health plan policy, contract provision, or rationale upon which the termination decision was based; and facts specific to the enrollee and relevant to the coverage determination that is sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.

DND- Detailed Notice of Discharge is a notice given to a member who already received the Important Message in an acute setting by the hospital after the member has requested a QIO review of the hospital's decision to discharge from the acute setting. The DND explains the reason why the services will no longer be covered, provides a description of the Medicare coverage restrictions, and explains how those rules apply to the member's case.

HHA – Home Health Agency

IMPORTANT NOTICE: The Hospital issues an Important Message from Medicare [IM] within 2 calendar days of admission and not more than 2 calendar days prior to discharge for all Medicare inpatient hospital admission.

NOMNC – Notice of Medicare Non-Coverage – Formal letter to Medicare members informing them of the last day of coverage.

QIO - Quality Improvement Organization – Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve care given to Medicare enrollees. QIO's review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

SNF – Skilled Nursing Facility

PROCEDURE:

1. The IPA will track all Medicare member admissions to Hospitals, SNF, HHA, Hospice and CORFs.

2. The IPA is responsible to ensure that the appropriate health plan's NOMNC templates, filled out per CMS instructions, are utilized, and sent to the facility/provider within 2 visits/days of termination of coverage or, to all members receiving SNF, HHA or CORFs services. The notice will include the Optional Attachment to assist with documentation.

3. The proof of receipt by the member will come in the form of the signature by the member or his or her representative. The member or his representative is responsible for acknowledging receipt of the NOMNC upon receipt.

4. If a member refuses or is unable to sign the NOMNC notice, the Optional Attachment to assist with documentation will be filled out by the SNF, HHA or CORF representative.

5. The member or his/her Representative is responsible for contacting the QIO within the specified timeframe if he or she wishes to obtain an expedited review.

    a. If the member is in an acute Hospital setting and wishes to appeal to the QIO following the receipt of the Important Notice from the acute Hospital, the Concurrent Review Nurse will issue a DND – Detailed Notice of Discharge to both the member and QIO as soon as possible but no later than noon following the day after notification from the QIO. If a member or their representative requests more detailed information prior to requesting a QIP review, the DND letter may be sent to the member in advance of the member requesting a review.
    b. If a member is in a SNF, HHA, CORF or Hospice setting and wishes to appeal to a QIO, upon notification of the appeal from the QIO, the Concurrent Review Nurse will prepare and submit the DENC, [completed per CMS instructions with elements listed in definition of DENC above] to both the member and QIO within the close of business day of the date notified by the QIO. Medical records will be supplied upon request. Services may continue during the appeal.

6. The QIO will make the determination within the close of business day of receipt of all information.

- If the QIO overturns the decision, the authorization will be continued to the provider as stated in the QIO decision.
- If the QIO overturns the decision, the IPA will issue a new NOMNC when new discharge orders are written to be delivered at least two calendar days before Medicare covered services end.

7. If the member or their representative disagrees with the QIO's determination, the member may file a request for a hearing with the ALJ.

FORMS:
Not applicable

REFERENCES:
Part C&D Enrollee Grievance, Organization/Determinations, and Appeals Guidance 08.2022, Section 100.2.1; Form Instructions for the Detailed Explanation of Non-Coverage (DENC) CMS-10124

SUBJECT: Treatment Authorization & Eligibility [AB1324] **POLICY:** UM33

DEPARTMENT: Utilization Management & Claims

Effective Date: April 2008
Revision Date: August 2015
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To establish requirements for rescinding and modifying of an authorization for services after January 1, 2008, ensuring that that no authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reason, including, but not limited to, subsequent rescissions, cancellations or modification of the member's contract or when the delegate did not make an accurate determination of the member's eligibility.

POLICY:

AB 1324: This bill was signed by the governor amending the Health and Safety Code section 1371.08 and section 796.04 of the Insurance Code stating authorizations may not be rescinded, modified or denied after services have already been provided in good faith. This bill does not preclude the rescinding of a treatment authorization within reasonable time before services are rendered.

The IPA will show good faith by authorizing appropriate services and providing both an effective and expiration date.

The Provider will in good faith verify eligibility on the day services are to be provided and maintain documentation.

The IPA will have a process in place to review all authorized services on a monthly basis and identify cases where members may have lost eligibility and still have open referrals.

If the IPA becomes aware of a member's change in enrollment prior to treatment, the IPA must in contact the provider and send a formal notification to the provider of any rescinding of authorization.

If the Provider can show documentation of eligibility of the date of service provided, the claim for his services may not be denied.

When a Provider provides services in good faith and a member's eligibility has been retroactively cancelled, financial responsibility for the claims goes according to the contract with the members health plan. In some cases, the health plan has accepted financial responsibility. In other cases, the IPA is financially responsible.

PROCEDURE:

a. The UM Department will perform a monthly review of all OPEN authorizations to assess current eligibility of members.
b. Providers will be notified of any OPEN authorization for members who are no longer eligible. Notification letter will include instructions to bill if services were already rendered.
c. Claims that are received for authorized services where a member's eligibility was retroactively terminated, will require proof of eligibility verification within 1 day of services provided. If the provider shows good faith verification, the claim will not be denied.
d. Financial responsibility of services provided, and retro termination of the member is as according to the IPAs contract with the member's health plan.

FORMS:

Modification/Denial Letters

REFERENCES:

Health Net Provider Update #07-642

SUBJECT: Distribution of Affirmative Statement About Incentives **POLICY:** UM 32

DEPARTMENT: Utilization Management

Effective Date: May 1, 2007
Last Revision Date: August 15, 2019
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define the process for ensuring all providers, members and employees are notified of the IPA's Affirmative Statement about Incentives.

POLICY:

Medical Groups do not participate in economic profiling as defined in Health & Safety Code 1367.02.

Annually the UM Committee members and any provider making referral determinations will sign an attestation stating the following:

> *[IPA/Medical Group Name] requires that all utilization decisions regarding coverage and/or services must be based upon appropriateness of care and services. Financial rewards or incentives must not influence any utilization decisions. Financial rewards or incentives may be used to encourage efficient and appropriate care. To assure that the risks of under utilization are considered, no rewards or incentives can be issued that will discourage appropriate care and services to the members.*
>
> *[IPA/Medical Group Name] does not reward practitioners, providers or employees for issuing denials of coverage or service. All denials must be strictly based on insufficient medical appropriateness or not a covered benefit.*
>
> *In addition, practitioners are ensured independence and impartiality in making referral decisions that will not influence Hiring, Compensation, Termination, Promotion or any other similar matters.*
>
> *We the undersigned understand and will abide by these statements:*

Upon employment, all HealthSmart MSO Staff sign and attest to the following statement:

> *Undersigned also agrees to not accept any reward for issuing denial of coverage or service to the members and to ensure member healthcare is not compromised. All denials must be based strictly upon insufficient medical appropriateness or not a covered benefit.*

PROCEDURE:

A. Annually, the UM Committee and other provider making referral determinations will sign the Denials & Incentive Statement.

B. A written version notice to all Providers is sent that includes the Affirmative Statement about Incentives and other important utilization related items (i.e., how to obtain copies of criteria, how to contact medical director, etc.)

C. Members will also be sent a written notice of the IPA/Medical Groups Affirmative Statement. The information sent to members must first be reviewed and approved by the Health Plans prior to distribution.

D. HealthSmart employees are required to sign a Confidentiality Statement which also includes an attestation that they will not accept rewards or incentives for denials of service. Any violation of this statement will result in disciplinary action up to termination. These statements are completed upon new hire for all MSO staff and annually thereafter for all UM staff who make determinations (approvals, benefits etc.).

FORMS:

Denial & Incentive Statement

REFERENCES:

Health & Safety Code 1367.10(a)
Health & Safety Code 1367.02

SUBJECT: Referral for PKU Services Policy # UM 31
DEPARTMENT: Utilization Management

Effective Date: July 2005
Last Revision Date: February 2007
Last Review: January 2026

SCOPE:
This policy applies to all Medi-Cal lines of business

PURPOSE:
To define the process for authorization of testing and treatment for Phenylketonuria (PKU).

POLICY:
All newborn members (up to age 6 months) will be tested for PKU.

All newborn members who test positive for PKU will be referred for appropriate testing and treatment; treatment will include special foods and formulas.

All members with documented diagnosis of PKU will be referred to California Children Services (CCS).

Referrals are to be documented in the member's medical record.

DEFINITION:

Phenylketonuria (PKU): A hereditary disorder in which the amino acid phenylalanine isn't properly metabolized. This amino acid occurs in significant amounts in all proteins, including breast milk, standard baby formulas, eggs, meat, fish and beans. People with PKU can't process phenylalanine because they lack an enzyme called phenylalanine hydroxylase (PAH). As a result, the amino acid can build up to dangerous levels in the blood and other tissues, causing mental retardation and other serious health problems. Approximately one of every 15,000 babies in the United States is born with PKU. Mental retardation can be totally prevented if these babies begin a carefully regulated low-phenylalanine diet just after birth.

Required Coverage: California legislation (SB148) requires coverage for:

1. Testing for PKU
2. Appropriate treatment by a physician specializing in metabolic disorders
3. Medically necessary formulas and special food products that are part of a diet designed to avert development of PKU-related physical and mental disabilities.
    a. Food products must be used in the place of normal food and be prescribed as medically necessary by a physician or other practitioner and managed by a health care professional.
    b. Coverage does not include food that is naturally low in protein but may include a food product that is specially formulated to have less than one gram of protein per serving.

PROCEDURE:

A. All newborns will be screened for PKU within 2-7 days after birth.

B. All newborns testing positive for PKU will be referred by the PCP to a metabolic disease specialist for evaluation and treatment.

C. All referrals for members with a diagnosis of PKU will be referred to California Children Services (CCS).

    a. If CCS approves the referral, all treatment services will be authorized by and covered by CCS.

FORMS:

Referral Authorization Request Form

REFERENCES:

Not applicable

SUBJECT: Transportation Services **Policy #:** UM30

DEPARTMENT: Utilization Management

Effective Date: April 26, 2005
Last Revision Date: September 30, 2021
Last Review: January 2025

SCOPE:
This policy applies to all lines of business.

PURPOSE:
To clarify the scope of emergency, non-emergency medical and non-medically indicated transportation services.

POLICY:
Transportation services are covered for the purpose of obtaining medically necessary care for members who are sick, injured, invalid, convalescent, infirm, or otherwise incapacitated and for whom ordinary public or private conveyances are contraindicated. These services are identified as follows:

1. Emergency medical transportation under the direction of paramedics is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the member.

2. Non-emergency medical transportation by ambulance, litter van, wheelchair van and air are covered when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and the transportation is required for the purpose of obtaining medically necessary services, including Early and Periodic Screening, Diagnosis and Treatment [EPSDT] services and carve out services including but not limited to Specialty Mental Health Services, substance use disorder services and dental services. Transportation may be authorized when a member cannot reasonably ambulate or is unable to stand or walk without assistance, including those using a walker or crutches. Services are to include door to door assistance. All non-emergency medical transportation requires prior authorization with the exception of transfers from an acute care hospital immediately following an inpatient stay at an Acute, Skilled Nursing facility or licensed Intermediate Care facility.

3. Non-medically indicated transportation such as travel by passenger car, taxi or other forms of public or private transportation, is not a covered benefit. Exceptions to this rule may be determined on a case-by-case basis at the discretion of the IPA.

   Effective July 1, 2017, Non-Medical Transportation [NMT] is a covered Medi-Cal benefit and the responsibility of the Plan to facilitate and authorize. Types of Non-Medical Transportation may include but is not limited to members picking up prescription at pharmacy, pick up of medical supplies and equipment.

Members will be advised of Community Resources for other transportation needs available in their geographic area including but not limited to Buses, Services for Disabled members, Senior Mobility Programs, Train services.

Referrals for Non Emergency Medical Transportation will be coordinated using the member's health plan referral form, or when not delegated, by contacting the health plan's designated transportation coordinator, as per the plan's required coordination process. Any referral form utilized must be approved by the Department of Health Care Services and will be used to determine the appropriate level of service.

When a Non-Emergency Medical Transportation Authorization Request Form is utilized, it must be fully and accurately completed by the treating physician [ie. physician, dentist, podiatrist, physician extender, mental health or substance use disorder provider] before NEMT services can be provided.

NEMT services include transportation to in-network and out-of-network providers who do not meet time and distance standards for medically necessary services that are prior authorized using the plan's required process for prior authorization. This would also include transportation to obtain medically necessary authorized services to an OB/Gyn provider who is outside the time and distance standards.

The group will not modify an authorization once the member's treating physician prescribes the form of transportation. The group will not impose a limit on NEMT as long as the member's medical services are medically necessary services and prior authorized.

The group will maintain a log of all NEMT referrals.

Effective July 1, 2019, members enrolled in the Whole Child Program may be eligible for Maintenance and Transportation [M&T] depending upon the specific diagnosis and guidelines. The benefit may include Transportation, Lodging and Meals, in and out of county and out of state where indicated. The Case manager will assist the member/parent/legal guardian with timely coordination with CalOptima for Authorization of these services. This benefit is directed to, coordinated by and paid through CalOptima.

CalOptima is responsible to make all arrangements. Transportation will be covered if there are no other resources to assist including if the member's parent/legal guardian has no means of reaching the approved facility or there are no alternate resources for these services available within the community. If the Member and/or parent/legal guardian choose to go to a Provider or Facility that is not the closest CCS approved facility or Provider, transportation costs beyond the closest available provider are the responsibility of the Member and/or Parent/Legal Guardian.

Reimbursement for meals and lodging is a benefit if:

1. The distance from the CCS Eligible member's home to the facility/provider authorized to provide service is such that the trip cannot be made in 1 day; or
2. If the parent/legal guardian is staying with and supporting a hospitalized CCS-eligible Member and the distance to the member's home to the facility cannot be made in 1 day; and the parent/legal guardian have no means of providing their maintenance without assistance from CalOptima; or when the parent/guardian is not permitted to stay at the beside. CalOptima will determine the length of coverage based upon the need and will maintain a log of all maintenance and transportation expenses, including but not limited to parking and tolls.

Meals and lodging may not be covered if the family can make the trip within 1 calendar day. CalOptima is responsible for determining approval and denial of this service. Should a request for Maintenance and Transportation be denied, CalOptima will provide the member with the appeal rights and process for appeal.

For members in the Whole Child Program who require transportation services that are not related to their CCS eligible diagnosis, transportation services will be covered under their Medi-Cal benefit.

DEFINITIONS:

Authorization: Approval granted by designated licensed staff in advance of rendering of a service, unless otherwise specifically stated, after appropriate medical, dental, or other review.

Emergency Services: Covered Services furnished by a qualified provider which are needed to evaluate and stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

Emergency Medical Condition: A medical condition, which 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 the individual in serious jeopardy (or the health of mother and unborn child in the case of a pregnant woman)
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Maintenance & Transportation: Available to members in the Whole Child Program meeting specific criteria for specific diagnosis and treatment of CCS Eligible Conditions. Benefit may include transportation, lodging and meals.

Medically Necessary: Reasonable and necessary services to protect life, to prevent significant illness or significant disability or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury**.**

Prior Authorization: See "Authorization"

Provider: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, or other person or institution that furnishes health care items or services.

PROCEDURE:

I. Emergency Transportation – No prior authorization required

A. Paramedics:

1. Appropriate for member who has a potential life-threatening condition
2. Call 911 for paramedic services

II. Non-Emergency Medical Transportation

Prior authorization request must be submitted with the required DHCS approved Physician Certification Statement (PCS) Form for all NEMT requests.

A. Ambulance

1. Appropriate for member who:
    a. Has an unstable medical condition;
    b. Needs specialized services, equipment and personnel of an ambulance
2. Examples of when to use
    a. Unstable member being transported from hospital to hospital, hospital to SNF or home to hospital.
    b. Transport from facility to facility (hospital to hospital; hospital to SNF; home to hospital

B. Litter Van
    1. Appropriate for member who:
        a. Must be transported in a prone or supine because of inability to sit for a period of time
        b. Requires specialized equipment and more space than is normally available in passenger cars, taxicabs or other forms of public transportation
        c. Does not require the specialized services, equipment and personnel of an ambulance
    2. Examples of when to use:
        a. Member in a Spica cast
        b. Bed-bound member
        c. Post-operative stable member who cannot tolerate sitting upright for the time required for transport from pick-up point to medical care destination.

C. Wheelchair Van
    1. Appropriate for member who
        a. Is unable to sit in a private vehicle, taxicab or other forms of public transportation for the time needed for transport
        b. Is wheelchair bound and unable to transfer unassisted from a residence to a public or private conveyance because of a disabling physical or mental condition
        c. Does not require the specialized services, equipment and personnel of an ambulance
    2. Examples of when to use
        a. Wheelchair bound member who suffers from severe mental condition
        b. Member with quadriplegia
        c. Member with paraplegia
        d. Wheelchair bound Dialysis patients

D. Air Ambulance
    1. Appropriate for member transferring from one hospital to another when:

        a. Medical Necessity criteria is met
        b. Higher level of care is required, and the transferring facility is unable to provide the medical services required (i.e. burn care, cardiac care, trauma care, critical care)
        c. The receiving facility is not readily accessible to ground medical transportation
        d. A written order of a physician, dentist, podiatrist or mental health or substance use disorder provider can substantiate the necessity
        e. Coordination with health plan for authorization may be required.

III. Transportation for Minors

Transportation can be coordinated for a minor with the written consent of the parent or guardian that the minor may access transportation services unaccompanied. All necessary written consent forms must be received prior to arranging or authorizing services for an unaccompanied minor.

1. Written consent is not required for an unaccompanied minor when state or federal law does not require consent for the services, [i.e. Sensitive Services for minors]

IV. Non-Medical Transportation (NMT)

When a NMT need is identified or requested by a member or provider, a warm transfer to the member's plan will be performed to assist in coordinating services.

V. Maintenance and Transportation for Whole Child Model – CCS eligible members - CalOptima:

1. The Health Network will identify a CCS-Eligible member who may be eligible for the Maintenance and Transportation benefit through communication with the Member, family/parent/legal guardian and confirmation of an approved treatment request that has met CCS criteria.
2. The Health Network will forward a completed WCM Maintenance and Transportation Assistance Worksheet to CalOptima including a copy of the approval notice of the medical procedure or treatment for which the Maintenance and/or Transportation is needed.
3. CalOptima will coordinate the M&T needs with the member, family/parent/legal guardian.
4. If the request for M&T is denied, CalOptima will provide alternatives and include the information on how to appeal the denial decision.

SUBJECT: Continuity of Care for Members Involuntarily Transitioning Between Providers **Policy #:** UM29

DEPARTMENT: Utilization Management

Effective Date: July 1, 2000
Last Revision Date: July 7, 2020
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure continuity of care for members involuntarily transitioning between providers in accordance with the Knox-Keene Act and applicable regulations.

For plans that do not delegate, or where partial delegation exists, the group will follow the plans required coordination process and refer the member to the health plan as applicable. For example, Cigna delegates review and approval of COC but if COC cannot be approved, it must be sent to Cigna for review and denial of COC.

POLICY:

An IPA shall provide for continuity of care for members involuntarily transitioning between providers in accordance with the terms and conditions of this policy, the relevant provisions of the Knox-Keene Act and applicable regulations.

Involuntary transitioning between providers shall apply to new enrollees when the member does not have a choice of another health plan (i.e. PPO, POS, etc.) and if enrolled in a group (not individual) plan and one of the six medical conditions are met.

Involuntary transitioning between providers shall apply to existing members when a provider is terminating contract with the health plan or IPA and one of the six medical conditions are met.

Upon notification of a Terminated Provider, the UM Manager will Review all open encounters, referrals and denials related to the affected provider and identify members who are in an active course of treatment, including but not limited to, approved referrals for elective surgery within the last 180 calendar days, open and approved referrals within the last 180 calendar days, Admissions for patients currently in acute hospitals, skilled nursing facilities, and acute rehabilitation units and/or open referrals for prenatal and postpartum services, if applicable to the provider.

At the request of an Affected Member, an IPA shall consider approving the completion of Covered Services for such Member who has one of the following conditions of this policy:

1. An Acute Condition, for the duration of the acute phase;

2. A Serious Chronic Condition;

3. A Pregnancy, including all 3 trimesters;

4. A Terminal Illness, likely to result in death in one year or less;

5. The care of a newborn child between the ages of birth and thirty-six (36) months, or

6. Performance of a surgery or other procedure that has been authorized as part of a documented course of treatment and has been recommended and documented by a provider to occur within one hundred and eighty (180) calendar days after the Participating Provider's contract termination date.

Reasonable consideration will be given to the potential clinical effects on the members' treatment caused by a change in provider in identification of members that may require continuation of services. This is accomplished by reviewing appropriate medical records, in collaboration with the Medical Director, PCP and the treating provider.

The health plan, in its sole discretion, may make reasonable and medically appropriate provision for assumption of services on behalf of a member.

Notifications to members will be in writing and will include the name of the terminating provider, effective date of the termination and process to select another provider. Notice of termination through a member newsletter or web posting is not adequate notification.

DEFINITION:

Acute Condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem which requires prompt medical attention, and which has a limited duration. Continuity of Care (COC) is provided for the duration of the acute condition but shall not exceed twelve (12) months from the contract termination date.

Affected Member: A Member who is transitioning involuntarily between providers due to a provider contract termination.

Care of a Newborn Child: between birth and the age of 36 months. Continuation of care is provided for the duration of the chronic condition but shall not exceed twelve (12) months from the contract termination date.

Chronic Condition: A medical condition, usually of slow progress and long continuance, and other than a Serious Chronic Condition, requiring ongoing care. COC is provided for the duration of the chronic condition but shall not exceed ninety (90) days from the contract termination date.

Medically Necessary: Reasonable and necessary services to protect life, to prevent significant illness or significant disability or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

Mental Health Acute Condition: A mental health condition that involves a sudden onset of symptoms that requires prompt mental health attention and that has limited duration. Transition period of 90 days or through the acute period of illness, whichever is shorter, to continue course of treatment with the nonparticipating mental health specialist.

Mental Health Serious Chronic Condition: A mental health condition that is serious in nature and requires ongoing treatment to maintain remission or prevent deterioration. Transition period of 90 days or through the acute period of illness, whichever is shorter, to continue course of treatment with the nonparticipating mental health specialist.

Participating Provider: A provider who is obligated by a written contract to provider covered services to members on behalf of an IPA. Note: this includes physicians, hospitals, clinics, etc.

Pregnancy: Continuation of care through the three trimesters of pregnancy and the immediate postpartum period.

Primary Care Physician: A physician who focuses his or her practice of medicine to general practice, family practice, pediatrics. Internists and, obstetrician/ gynecologists, may also be defined as PCPs if they provide primary care. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under the Medi-Cal managed care program.

Performance of Surgery or Other Procedure: that is authorized by the plan as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 calendar days of the contract's termination date.

Routine Request: A request for continuity of care for covered services that are planned interventions for health care needs and do not require urgent or expedited processing.

Serious Chronic Condition: A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Continuation of care is provided for the duration of the chronic condition but shall not exceed twelve (12) months from the contract termination date.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing death within one year or more. Completion of covered services shall be provided for the duration of the terminal illness.

Terminated Provider: A provider whose contract to provide services to members has been terminated by the IPA or the provider.

Urgent Request: A request for continuity of care for covered services that are required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

PROCEDURE:

A. Notice

1. Commercial & Medi-Cal Members will be notified sixty (60) calendar days in advance of a Participating Provider termination and Medicare Advantage Members will be notified in thirty (30) calendar days of the termination date.

2. Medicare members will be notified within 30 calendar days before the effective date of termination. The CMS approved member notification letter template will be used. Member notification materials will adhere to all state language requirements to include member rights to COC (DMHC).

3. For Medi-Cal and Commercial members, the notice will contain the following statement:

   > "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact [List the IPA or Health plan – according to plan requirements] customer service department at [telephone number]. If you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects IPA customers, by telephone at its toll free number, 1-888-HMO-2219 or TDD number for the hearing impaired at 1-888-688-9891, or online at www.hmohelp.ca.gov.

   and will have the LAP Notice of Translation, approved by the DMHC attached to the notice.

4. For Cal MediConnect/Duals Program: Members will be notified 15 days after receipt of a Specialist Provider Termination notice via written notice. Evaluation of activity with the Specialist will be reviewed and where necessary one-time contracts may be put in place to maintains continuity of care. There will be no disruption to care for members with Chronic or ongoing medical condition or receiving Long Term Support Services.

5. The IPA will notify an affected member of its decision to approve or deny a request for continuity of care within the following timeframes:

   a. Urgent Request: Within one (1) calendar day after the date of the IPA's decision by electronic, phone or verbal notification and within two (2) working days after the date of the IPA's decision, by written notification.

   b. Routine request – within two (2) working days after the date of the IPA's decision.

6. If after sending a notice to the member, the organization reaches an agreement with the terminated provider to renew or enter into a new contract or to not terminate their contract, the organization shall offer affected member the option to return to that provider. This notice may be verbal or written.
7. When a terminated provider either reaches or signs a new agreement with the medical group, member notice will be sent within 20 days of the original termination date and offer the member the option to return to the provider.

8. This policy will be made available to members upon request.

B. Processing a request for continuity of care

1. An IPA will assist an affected member to complete a request for continuity of care.

2. Upon receipt of the request, the IPA will be responsible for collecting all medical records and other information necessary to review the request for continuity of care.

3. The IPA shall make a decision regarding the request for continuity of care within the following timeframes:

    a. Urgent Request: Within one (1) calendar day after the receipt of all medical records and other information.

    b. Routine Request: Within two (2) working days after the receipt of all medical records and other information.

C. IPA shall give reasonable consideration to the potential clinical effects on an affected member's treatment caused by a change in provider and shall consider the following criteria in adjudicating a request for continuity of care:

1. Determine if the member has one of the conditions described in the Policy section of this policy.

2. Determine if the member is in the middle of treatment for such condition;

3. Determine if transitioning the member to a new provider would compromise the treatment plan or worsen the condition of the member; and

4. Determine if the member can be safely transitioned to a participating provider instead of continuing with the terminated provider.

D. Duration of continuity of care

1. If the request is for continuity of care for an acute condition, the IPA shall provide continuity of care for the duration of the acute condition.

2. If the request is for continuity of care for serious chronic condition, the IPA shall provide continuity of care for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider.

3. If the request is for continuity of care for a pregnancy, the IPA shall provide continuity of care for the duration of the pregnancy.

4. If the request is for continuity of care for a terminal illness, the IPA shall provide continuity of care for the duration of the terminal illness.

5. If the IPA approves an affected member's request for continuity of care of a newborn child between the ages of birth and thirty-six (36) months, the IPA shall provide continuity of care for a period of time not to exceed twelve (12) months from the terminated provider's effective date of contract termination.

6. If the IPA approves an affected member's request for performance of a surgery or other procedure that has been authorized as part of a documented course of treatment and has been recommended and documented by a provider to occur within one hundred and eighty (180) calendar days after the Participating Provider's contract termination date.

7. These decisions are arrived at in consultation with the member and the non-participating provider and are consistent with good professional practice. It is not to exceed twelve (12) months from the terminated provider's effective date of contract termination.

E. Notice of a decision to an affected member

1. An IPA shall notify an affected member of its decision to approve or deny a request for continuity of care within the following timeframes:

   a. Urgent Request – within one (1) calendar day after the date of the IPA's decision by electronic, phone or verbal notification and within two (2) working days by written notification.

   b. Routine Request – within two (2) working days after the date of the IPA's decision.

2. The notice of the decision shall contain the following:

   a. The decision

   b. If approved, the length of time for which the covered services shall be provided, as identified in section D, and instructions regarding the need for future or subsequent authorizations, and;

   c. If denied, the reason for denial, the alternate providers within the IPA who will complete care, instructions for accessing care, and notice regarding an affected member's right to appeal the denial in accordance with the IPA's complaint policy.

F. Transitioning care from a terminated provider to a participating provider

1. The IPA will develop a transition of care plan immediately upon learning of a provider's intent to terminate.

2. This transition of care plan will stand regardless of whether the IPA approves or denies a specific member's request for specific continuity of care

3. If a member's request for continuity of care is denied, the IPA shall coordinate the transfer of medical records to the participating provider to whom the affected member is transitioning.

G. Provision of Covered Services

1. The IPA may require a terminated provider whose services are continued pursuant to this policy to accept the terms and conditions that are imposed upon participating providers who are not capitated. These would include: rate of payment, credentialing, hospital privileging, utilization review, peer review and quality improvement requirements. If the terminated provider does not agree to comply, the IPA is not required to continue with his/her services.

2. The IPA Contract Manager will coordinate a one-time contract with the provider for the duration of member's care. Neither the health plan or the IPA shall be obligated to continue services of a terminated provider is he/she refuses to accept the terms of the one-time contract.

3. The affected member, utilizing a provider with a one-time contract, will be required to pay all co-payments, deductibles or other cost of share expenses during the completion of covered services with a terminated provider.

4. Neither the health plan or the IPA shall be required to provide completion of covered services for a terminated provider if that provider's contract has been terminated for reasons relating to medical disciplinary cause, fraud or other criminal activity.

5. Neither the health plan or the IPA shall be required to cover services or benefits that are not otherwise covered plan.

FORMS:

For CalOptima:
Template Notice to Affected Members
Request for Continuity of Care

REFERENCES:

SB 1129 Continuing Coverage of Services by Terminated Provider

SUBJECT: Referral to WIC Policy # UM 28
DEPARTMENT: Utilization Management

Effective Date: February 2005
Last Revision Date: December 4th, 2023
Last Review: January 2026

SCOPE:

This policy applies to all Medi-Cal lines of business.

PURPOSE:

To define the process for referring all eligible female members and young children to the Women, Infant and Children (WIC) Supplemental Food Program.

POLICY:

All members who are pregnant, breastfeeding, and postpartum women, infants, and children under the age of five (5) will be referred to WIC.

To ensure that IPA members receive adequate nutrition during pregnancy and the postpartum period, each member's nutritional status shall be assessed:

- At the first prenatal visit or the CPSP visit
- At least once each trimester
- At least once during the postpartum period.

All primary care providers are to identify candidates for the program by performing nutritional assessments, as well as, hemoglobin and hematocrit tests on children under the age of five (5).

All members are eligible to receive WIC services to facilitate and encourage adequate nutrition during pregnancy and the postpartum period.

Test results reported on a CHDP form PM 161 for children or the CPSP assessment tool are to be provided to the WIC program with all referrals.

Referrals are to be documented in the member's medical record.

DEFINITION:

Women, Infant and Children Supplemental Food Program (WIC): A federal program that provides nutritional education and vouchers to purchase specific foods to eligible women and their infants and small children. Food vouchers offered include milk, eggs, cereal, juice, iron-fortified formula, and infant cereals.

PROCEDURE:

A. At the time of the first prenatal visit/initial assessment with the pregnant member:
    a. A nutritional assessment will be completed;
    b. Recommendations specific to the member's individual dietary needs will be made to the member;
    c. The WIC referral form will be completed and given to the member.

B. PCPs are to perform a nutritional assessment, hemoglobin, and hematocrit on young children to assess dietary intake. Results are to be documented:
    a. In the medical record
    b. On a PM 161 form.
    c. The WIC referral form will be completed, and a copy given to the member.

FORMS:

WIC Referral Form

REFERENCES:

Not applicable

SUBJECT: Mental Health Services **Policy #:** UM 27
DEPARTMENT: Utilization Management

Effective Date: February 2005
Last Revision Date: February 2007
Last Review: January 2026

SCOPE:

This policy only applies to IPAs that are delegated for these services. If not delegated, the coordination of these services is the responsibility of the health plan.

PURPOSE:

To define the Mental Health benefits when coordination of these services is delegated to the IPA.

POLICY:

IPA shall provide unlimited coverage for mental health services that meet the definition of Severe Mental Illnesses (SMI) or Severely Emotionally Disturbed (SED) Children or Adolescent. Coverage for other mental health services shall be limited to evaluation, crisis intervention, and treatment for conditions that are subject to significant improvement through relatively short-term therapy. This includes treatment of children who have experienced family dysfunction or trauma. Family Members may be involved in the treatment, if appropriate.

The Primary Care Physician (PCP) shall be responsible for monitoring the treatment, whether the services are covered by the HFP or by the County, in order to ensure coordination of care and appropriate medical monitoring.

Inpatient Services:

> Inpatient mental health services will be covered when ordered and performed by the Member's HFP participating mental health professional for the treatment of an acute phase of a mental health condition during a certified confinement in a Member's participating HFP network hospital.
>
> Limit: Thirty (30) inpatient days per Benefit Year, except for the treatment of SED children with SMI, which are unlimited.

In lieu of an inpatient hospital day, an IPA may, with the agreement of the member or other responsible adult, substitute any of the following:

- Two (2) days of residential treatment
- Three (3) days of day-care treatment or
- Four (4) outpatient visits

Outpatient Services

> Outpatient mental health services will be covered when ordered and performed by a member's HFP participating mental health professional.

- Up to 20 visits per benefit year will be covered except for the treatment of SED and SMI, which are unlimited. IPAs may elect to provide additional visits.
- Prior authorization may be required.

Emergency Services

Mental health covered services include emergency services for psychiatric screening, examination, evaluation and treatment by physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges. Emergency services include care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of a facility.

Exclusions

Participating IPA providers will be responsible for identifying excluded diagnoses.

Providers will also be responsible for identifying members who are SED and shall refer those members to the County Mental Health Department. The county is responsible for authorization, service, and payment in those cases.

IPAs will be responsible for identifying and referring members who have a condition for which they may be eligible to receive services under the California Children Services (CCS) program.

IPAs will not be responsible for either the provision or payment of authorized CCS services.

IPA will provide primary care and other covered services unrelated to the CCS eligible condition and/or not authorized by CCS and will ensure coordination of services between health network providers, CCS providers, and the local CCS program.

DEFINITIONS:

Benefit Year: The twelve (12) month period beginning at 12:01 am of the health plan's start of a fiscal year.

Covered Services: Those medical services, equipment or supplies, which the health plan and the IPA are obligated to provide under written agreement. The health plan's agreement will be with the Managed Risk Medical Insurance Board (MRMIB). The IPA's contract will be with the health plan.

Severe Mental Illnesses (SMI): These include, but are not limited to:

Schizophrenia
Schizoaffective disorder
Bipolar disorder
Major Depressive disorders
Panic disorder
Obsessive-Compulsive disorder
Pervasive Developmental disorder or Autism
Anorexia Nervosa
Bulimia Nervosa

Severely Emotionally Disturbed (SED) Children or Adolescents: Minors under the age of 18 years of age who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSMMD) other than a primary substance use disorder or development disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population will meet one or more of the following criteria:

As a result of the mental disorder the child has substantial impairment in at least two (2) of the following areas: self-care, school functioning, family relationships, or ability to function in the community, and either of the following occurs:

The child is at risk of removal from home or has already been removed from the home.
The mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment

The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

The child meets special education eligibility requirements under Section 7570 of Division 7 of Title I, Chapter 26.5 of the Government code.

PROCEDURE:

A. HFP providers will request an authorization for mental health services from the member's IPA utilization management (UM) department. (See UM 4, Referral Authorization Process).

B. Upon receipt of the authorization request for mental health services, the IPA UM Department will process the request within their timeframes and policy guidelines.

C. Case Management will be notified of the referral.

D. Case Management will open a file on each member referred for mental health services.
1. The assigned case manager will work with the family, the PCP and the mental health provider to ensure that coordination of care occurs.
2. The case manager will handle all referrals.
3. An assessment and an ICP will be completed, and follow-up will occur at least monthly.

FORMS:

Not applicable

REFERENCES:

California Health and Safety Code Section 1374.72
Title I, Government Code, Division 2, Chapter 26.5, Section 7570
Title 10, California Code of Regulations, Chapter 5.8, Article 3, Section 2699.6700-6707
Welfare and Institutions Code, Section 5600.3 (a) (2)

SUBJECT: Initial Health Appointment **Policy #:** UM26
DEPARTMENT: Utilization Management

Effective Date: February 2005
Last Revision Date: February 6th, 2026
Last Review: February 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure that members receive an Initial Health Appointment (IHA) within the timelines outlined by contracted health plans.

POLICY:

Initial Health Appointment [IHA] can be performed by:

- Member's PCP of Record, other Primary Care Provider or General Practitioner
- Board Certified Specialists
  - o Internal Medicine
  - o Pediatrics
  - o OB/GYN
  - o Family Practice
- Non-physician Mid- Level Practitioners
  - o Nurse Practitioners
  - o Certified Nurse Midwifes
  - o Physician Assistants

IHAs can be performed in the following settings:

- Ambulatory Setting
- Hospital
- Skilled Nursing Facility
- Home

All Primary Care Physicians (PCPs) are responsible to pull their IHA report from the E-HealthCare portal each month, identifying newly enrolled members who have not completed the IHA. The PCPs are responsible for contacting these members to set an appointment to complete the IHA. The PCP will make all attempts to see the members within 120 days of enrollment and document each attempt.

The PCP must make a good faith effort to update the member's contact information, including updating information received by the post office for any change of address and from Directory Assistance for any new telephone number.

All members 18 months of age and older will receive an IHA within 120 calendar days of enrollment. For infants and children under the age of 18 months, the next AAP recommended periodic health assessment is due within 60 days following enrollment.

Commercial, Medicare and Medicare Advantage members are encouraged to be seen within the first three month of enrollment [90 days] for preventive services and periodic health assessments. Assessments may include but are not limited to age-appropriate exams, well baby exams, well woman exams, immunization needs and immunization for travel where covered, routine diagnostic labs and testing, osteoporosis exam, eye exams, cancer screenings, and health education.

All members will receive an Initial Health Appointment unless the member's primary care physician (PCP) determines that the member's medical record contains complete and current information to allow for assessment of member's health status and health risk in accordance with regulatory requirements and managed care contracts. When a prior IHA was completed within 12 months prior to enrollment, the new PCP must document the review of the previous IHA and update accordingly.

Other Exceptions to Exceptions to 120 Day IHA Timeframe may include but are not limited to a member having all elements of the IHA have been completed within 12 months prior to the member's effective date of enrollment, the member was not continuously enrolled or the member disenrolled before an IHA could be performed.

For members who are pregnant upon enrollment, or discovered to be pregnant prior to an IHA, the pregnancy must be noted, and an initial risk assessment must be completed, in addition to the referral for Obstetrical Care.

If a member fails an appointment for an IHA, a minimum of two additional documented attempts must be made to reach the member. The documentation must include one attempt to contact the member by telephone with the number provided by the plan and one attempt to contact the member by letter or postcard using the address supplied by the health plan.

When a member surpasses the deadline for an initial health appointment, an attempt to perform the IHA at any subsequent visits must occur until the IHA is completed or the member disenrolls from the plan.

Management Services Organization (MSO) will instruct providers in the need for a timely IHA for all members and shall track IHA's to ensure assessments are conducted within the timeframes specified by contracted health plans. Results of tracking of IHAs will be reported to the Quality Improvement Committee.

The Individual Health Education Behavioral Assessment Tool also known as "Staying Healthy Assessment" Tool will be administered to all new members within 120 days of the effective date of enrollment, as part of the initial health appointment, and to all existing members who present for a non-acute care visit or a scheduled health screening exam. As part of an IHA for Medi-Cal members, the provider must provide the member with an appropriate age specific Staying Healthy Assessment [SHA]. The SHA will assist the provider in treatment planning and identification of additional needs of the member. The SHA will be maintained in the member's file. A member's refusal to complete the SHA must be documented on the appropriate age-specific form and kept in the member's medical record. [See P&P HE2]. Members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g., well- baby, well-child, well-woman exam), according to the SHA periodicity table.

As part of the initial and annual health assessments, members are informed of specific health care needs that require follow-up and receive, as appropriate, information to support and promote their own health. Barriers to care will be discussed and documented and may include referral to Case Management to assist the members in ensuring their compliance with treatments planned. Timely coordination of referral to Case Management and/or additional referral for service needs will be documented.

ACIP-recommended immunizations are viewed as preventive services, these services must not be subject to prior authorization. Providers must document the Member's need for ACIP-recommended immunizations as part of all regular health visits including IHA.

DEFINITIONS:

Effective Date of Enrollment: The first day that a member's enrollment is in effect with a contracted health plan.

Effective Date of Enrollment for LA Care: LA Care defines the effective date of enrollment as the first day of the month following notification that a member is eligible to receive services from the delegate, for which capitation will be paid, and the member is not on "hold" status. For newborns, the date of enrollment is their birth date. For retroactive enrollment, the effective date for IHAs is the date the group is notified of the retroactive enrollment.

Effective Date of Enrollment for CalOptima: CalOptima defines the effective date of enrollment as the first day the member became eligible within CalOptima, not the date the member became effective within the group.

CSHCN: Defined as services for those members who have or are at risk for chronic, physical, behavioral, developmental, or emotional conditions and who require health or related services of a type or amount beyond that required by children generally.

Initial Health Appointment (IHA): A member's visit to his or her PCP or other provider of primary care services, within set timelines, as identified below, for an evaluation sufficient to enable the PCP to assume responsibility for effective management of the member's health care service needs.

Primary Care Physician (PCP): A physician who focuses his or her practice of medicine to general practice or who may be a board-certified internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to members, initiating referrals, and maintaining the continuity of member care.

PROCEDURE:

A. An IHA will include the following elements:

1. **For members under 21 years of age**:

a. All elements of the periodic health assessment as delineated by the American Academy of Pediatrics (AAP), California's Child Health and Disability Preventive Program (CHDP), and the Advisory Committee on Immunization Practices (ACIP). When examinations occur more frequently using the AAP Periodicity Schedule rather than the CHDP examination schedule, the IHA must follow the AAP Periodicity Schedule, and the scheduled assessments and services must include all content required by CHDP for the lower age nearest to the current age of the child. These include, but are not limited to:

1. Health & Developmental History, including Social History

2. Unclothed Physical Examination

3. Growth and Development

4. Nutritional Status

5. Allergies

6. Hearing & Vision Screening as indicated and as appropriate.

7. Immunizations as indicated and as appropriate to age and health history and maintain documentation of the Member's need for immunizations in the member file.
    i. Unsuccessful efforts to provide immunizations in accordance with the immunization schedule and recommendations must be documented. If immunizations cannot be given at the time of the visit, the Member must be instructed as to how to obtain necessary immunizations, or a scheduled and documented appointment must be made.

    ii. If a parent/guardian refuses an immunization service for their child, the PCP will require the parent/guardian to sign a refusal of vaccination form. If the parent/guardian refuses to sign the form the PCP must document the refusal in the medical record.

    iii. Upon federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, the PCP shall develop policies and procedures for the provision and administration of the vaccine. Such policies and procedures shall be developed within 60 calendar days of the vaccine's approval date regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with any Medi-Cal Fee-For-Service guidelines.

    iv. The IPA will provide the PCP information regarding the VFC Program.

    v. The PCP will follow the VFC Guidelines for New Vaccine Storage Equipment and Handling Guidelines, including requirement for type of unit required for providers receiving VFC vaccines and timeline for upgrading existing refrigeration units, as needed.

8. Evaluation of medication history, including but not limited to:

    i. Reconciliation of current and historic medications; and
    ii. Evaluation of potential misuse or contraindications; and
    iii. Use of illegal drugs or inappropriate use of legal substances, [i.e., Opioid use, alcohol, tobacco use, etc.]; and
    iv. Screening for potential substance use disorders, including a referral for treatment as appropriate.

9. Dental Screening

10. PPD

11. Lab Tests as appropriate to age and sex

12. Sickle Cell Testing when culturally appropriate

13. Hgb, Hct, & UA

14. Autism Spectrum Disorder specific screening for all children at ages 18 months and 24 months.

15. Lead Levels

Initial screening should be done at age 1 and 2, however if not previously screened, catch-up testing may occur between 26 and 72 months. Testing will occur at any age for those exhibiting symptoms relating to potential lead exposure, or for those children for which during the IHEBA questionnaire the parent/guardian responded to "yes" or "I don't know" to questions relating to regular visitation or currently living in a house built prior to 1978 or
has sibling or playmate who has or did have lead exposure.

The PCP is responsible to:

1) Provide oral or written anticipatory guidance to the parent(s) or guardian(s) of a child member that, at a minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.9 This anticipatory guidance must be provided to the parent or guardian at each IHA, starting at 6 months of age and continuing until 72 months of age;

2) Order or perform blood lead screening tests on all child members in accordance with the following:

a) At 12 months and at 24 months of age.
b) When the network provider performing an IHA becomes aware that a child member who is 12 to 24 months of age has no documented evidence of a blood lead screening test taken at 12 months of age or thereafter.
c) When the network provider performing an IHA becomes aware that a child member who is 24 to 72 months of age has no documented evidence of a blood lead screening test taken.
d) At any time, a change in circumstances has, in the professional judgement of the network provider, put the child member at risk.
e) If requested by the parent or guardian.

3) Follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees contained in the CLPPB issued guidelines.

The PCP is not required to perform a blood lead screening test if either of the following applies:

a) In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.

b) If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

    i. If blood level screen test is refused by member, proof for voluntary Refusal of the test in the form of a signed statement by the member if an emancipated minor or the parent(s) or guardian of the member shall be documented in the medical record.
    ii. If the provider is unable to obtain a signed statement of voluntary refusal because the party that withheld consent*:* 1) refuses or declines to sign it, or 2) is unable to sign it (e.g., when services are provided via telehealth modality), the provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record. The plan will consider the above documented efforts that are noted in the child's medical record as evidence of compliance with blood lead screening test requirements.

In addition to ensuring providers meet requirements for testing, follow-up care, and documentation, starting no later than January 1, 2021, health plans are required to identify, on at least a quarterly basis, all child members *under the age of* six years who have no record of receiving a blood lead screening test *as* required by Title 17 CCR section 37100. The plans must identify the age at which the required blood lead screenings were missed, including children without any record of a completed blood lead screening at each age. The Plans must notify the provider who is responsible for the care of an identified child member of the regulatory requirements to test that child and provide the required written or oral anticipatory guidance to the parent/guardian of that child member. PCPs must also maintain records, for a period of no less than 10 years, of all child members identified quarterly as having no record of receiving a required blood lead screening test and provide those records to DHCS, at least annually as well as upon request, for auditing and compliance purposes.

16. Health Education and Anticipatory guidance as indicated according to age and health.

17. Cervical Cancer Screening for members who are sexually active.

    i. Cervical Cancer Screening shall include the conventional Pap test, a human papillomavirus (HPV) screening test recommended by the U.S. Preventive Services Task Force (USPSTF), upon the referral (or self-referral) of the member's health care provider, (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care to the member and operating within the scope of practice otherwise permitted for the licensee).

ii. Routine referral processes are followed when the member, in addition to the conventional Pap test, requests a human papillomavirus screening test (HPV) recommended by the U.S. Preventive Services Task Force, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

18. Screening for Chlamydia and other STD screenings.

    i. The provider shall screen all females age 24 years and younger, who have been determined to be sexually active, for Chlamydia. Follow up of positive results must be documented in the medical record. Reasonable attempts to contact the appropriately identified Members and provide screening for Chlamydia. All attempts shall be documented. Documented attempts that demonstrate the PPG's unsuccessful efforts to contact a member and screen for Chlamydia shall be considered evidence in meeting this requirement. If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's Medical Record.

19. Documentation of the next required periodic health assessment and any follow-up necessary, prior to that visit.

20. All findings must be documented, and any abnormal findings will be documented with appropriate follow up as soon as possible but no later than 60 days.

21. Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral from the local CHDP program, an appointment shall be made for the Member to be examined within two weeks of the request.

22. Refusal of any service is documented in the member's file.

2. **<u>For members 21 years and older</u>**:

   a. The age at which the PCP will begin administering the senior assessment to a member will be based on the member's health and medical status, and not exclusively on the member's age.
   b. A comprehensive history and physical examination, including an initial preventive medicine evaluation, as well as the preventive health requirements delineated in the Guide to Preventive Services, a Report of the U.S. Preventive Services Task Force. These include, but are not limited to:

      1. Complete history, including social history, and physical examination including inspection of ears, nose, mouth, throat, teeth, and gums, etc.

2. Evaluation of medication history, including but not limited to:

    i. Reconciliation of current and historic medications; and
    ii. Evaluation of potential misuse or contraindications; and
    iii. Use of illegal drugs or inappropriate use of legal substances, [ie. Opioid use, alcohol, tobacco use, etc.]; and
    iv. Screening for potential substance use disorders, including a referral for treatment as appropriate.

3. Blood Pressure.

4. Height and Weight

5. Cholesterol screening

6. Clinical breast exam for women over 40 years of age.

7. Hgb/Hct and UA

8. Mammogram for women over 40 years of age.

9. Cervical Cancer Screening for members who are sexually active.

    i. Cervical Cancer Screening shall include the conventional Pap test, a human papillomavirus (HPV) screening test recommended by the U.S. Preventive Services Task Force (USPSTF), upon the referral (or self-referral) of the member's health care provider, (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care to the member and operating within the scope of practice otherwise permitted for the licensee).
    ii. Routine referral processes are followed when the member, in addition to the conventional Pap test, requests a human papillomavirus screening test (HPV) recommended by the U.S. Preventive Services Task Force, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

10. Screening for Chlamydia and other STD screenings.

    i. The provider shall screen all females age 24 years and younger, who have been determined to be sexually active, for Chlamydia. Follow up of positive results must be documented in the medical record. Reasonable attempts to contact the appropriately identified Members and provide screening for Chlamydia. All attempts shall be documented. Documented attempts that demonstrate the PPG's unsuccessful efforts to contact a member and screen for Chlamydia shall be considered evidence in meeting this requirement. If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member

shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the member's Medical Record.

11. Immunizations as appropriate and as recommended.
    i. If a member refuses an immunization service, the PCP will require the member sign a refusal of vaccination form. If the member refuses to sign the form the PCP must document the refusal in the medical record.

12. Dental Screening

13. PPD & Tetanus Toxoid.

14. Health Education as indicated.

15. An age appropriate IHA according to the most current edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) as documented by a history & physical & review of organ systems. (including screening for prostate cancer in 45 years of age for men with high risk and 50-70 for men with average risk)

c. All medically necessary diagnostic, treatment, and follow-up services identified during any health care visit must be initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow-up.

d. Documentation of any follow-up necessary as a result of the IHA, including diagnosis and plans for treatment for any disease.

3. For members who have been receiving services for chronic and/or complex problems prior to enrollment in the IPA, the PCP will:

   a. Plan for continuation of all services necessary to treat those preexisting conditions, including member needs for continuation of specialty care.

   b. Identify services being provided or needs for services by local education agencies, Regional Centers, early intervention programs, California Children's Services (CCS), and other special programs outside the group. [This includes Children with Special Health Care Needs.]

4. For members who are pregnant upon enrollment or who are discovered to be pregnant before an IHA has been performed, the initial prenatal care visit with the provider who will oversee the member's care during her pregnancy may be considered the IHA if it meets contractual requirements for a first comprehensive prenatal visit.

B. Timelines for the provision of an IHA begin on a member's Effective Date of Enrollment.

1. For infants and children under the age of 18 months, the next AAP recommended periodic health assessment is due within 60 days following enrollment.

2. For children 18 months of age and older, the IHA is due no later than 120 days following the member's effective date of enrollment.

3. For members who are pregnant upon enrollment or who are discovered to be pregnant prior to the performance of an IHA, the IHA will be performed as soon as possible.

4. For members who have a change of PCP, or other provider of primary services prior to completion of an IHA, the IHA will be performed within 120 days of enrollment or no later than 60 days after the date of change of provider.

C. Types of IHA visits

1. A single visit of sufficient length to perform:

    a. A comprehensive history and physical for members who are new to the provider, including an appropriate preventive medicine evaluation.

    b. A detailed review of history and physical for members who have elected to continue an established relationship with a PCP, including an appropriate preventive medicine evaluation.

    c. A history and physical examination of a newborn infant.

2. A combination of visits within the required timeframe, which, when taken together, meet the minimum requirements for an IHA.

D. Types of exams that do NOT meet criteria for IHA visits:

1. A single brief visit, e.g., a 10-minute visit for limited well childcare.

2. An office or other outpatient consultation visit requested by the member's PCP or another IPA provider regarding evaluation and/or management of a specific problem.

3. Perinatal visits, other than the initial complete assessment of a pregnant woman.

4. Urgent care and/or emergency type visits or services.

5. Follow-up visits to any of the above types of services for further diagnosis, consultation and/or treatment purposes, unless IHA requirements are met.

E. Documentation and Reporting

1. The performance of an IHA shall be documented in the member's medical record.

2. If the member is a child, under the age of 21, the same information will also be documented on a PM160 form and reported within 30 days.

3. Documentation on the medical record should include counseling, anticipatory guidance, risk factor reduction interventions and other follow-up treatment and/or referrals for problems noted.

4. If a comprehensive health assessment has been performed elsewhere, the PCP will request copies and document it in the medical record.

5. If an initial health appointment has not been performed elsewhere, the PCP office staff may use the Eligibility List (E-List) sent each month as a guide for notifying newly enrolled members.

6. Communication may be done either by phone call, or by form letters (copies should be kept to document efforts).

    a. The E-List may be used as a log for documenting notification.

    b. If the letter is returned, the letter will be kept for documentation.

    c. If phone numbers have been disconnected, this should be documented on the E-List.

    d. At least three (3) attempts to reach the member must be made and documented.

7. All pertinent information should be reported as encounter data.

F. Exemptions from IHA requirements

1. Adequate documentation of an IHA within a qualifying period prior to enrollment

    a. For members 21 years of age or older, the visit to their PCP or other provider of primary care services will be within 120 days of enrollment, and the medical record documentation will support that an appropriate examination was performed within the twelve-month period prior to the member's visit to the PCP.

    b. For members under the age of 21 years, the medical records must contain information sufficient to determine that the member is up to date with required periodic health assessments, in accordance with the most recent AAP recommendations.

        1. Documentation will meet all IHA standards and include an immunization history.

        2. In all cases, the member will be brought up to date regarding immunizations.

G. Discontinuous enrollment

1. Members who are not continuously enrolled in a plan for 120 days, or the period of time necessary to achieve the AAP periodicity standards for infants and children, may be exempted from IHA requirements,

2. Members, as identified by DHS with specific aid codes, are share-of-cost Medi-Cal beneficiaries.

3. Performance of an IHA during the course of another medical encounter:

    a. Members who are seen for an urgent or emergent visit or who are hospitalized may have a full history and physical performed that meets IHA requirements.

    b. Members who are seen by a specialist who is also serving as the member's PCP may have a full history and physical performed that meets IHA requirements.

    c. The PCP or other provider of primary care services will document where information may be found in the medical record and that he/she has reviewed the member's health history and physical examination(s) and has accomplished a targeted history and physical, as needed.

H. For Health Plans that oversee the IHA process

1. IPA Responsibility:

    a. The Member Services Department will send the PCP a member list by health plan, showing all eligible members, with (*) notation of new members. The (*) notation will appear next to the member's name until they have completed an encounter with the PCP.

    b. IPA may also receive lists of newly enrolled members from the contracted health plans. These lists will be compared to those already within IPA's system to identify the last date that the member was seen. If the member is seen, the date of service will be faxed back to the Health Plan representative.

    c. If no activity is shown on the health plan lists, the PCP will be sent a copy of the health plan's list with a reminder that the member needs to be seen. If the member has already been seen, the PCP will fill in the date seen and fax it back to IPA. The IPA staff will coordinate back with the health plan.

    d. IHA will send PCP copies of IHA Follow-Up forms pre-populated with members' name, address, and phone number. PCPs will use these to document follow-up attempts to reach the member and/or list the date an IHA was performed.

2. PCP Responsibility:

    a. On a monthly basis, the PCP will review their eligibility lists for new members.

    b. The PCP will contact the member to set up an appointment for an IHA, performing all age-appropriate services and education. A treatment plan and any interventions will be clearly documented.

    c. The PCP will document three (3) attempts to contact the member to set up an appointment. This may be done by contacting the member by telephone and/or sending an appointment card.

d. If the member fails the scheduled appointment(s), a missed appointment letter will be sent. (see attached)

e. The PCP's office is responsible for responding to all requests from the health plans regarding IHA, making sure to copy IPA on all responses. (See #3 under IPA Responsibility).

f. If the PCP exhausts his attempts to get the member in for an IHA and receives a notice from the health plan, the PCP will document all dates attempting to reach the member. This information will be forwarded to the Health Plan representative.

g. If the PCP does not have a valid telephone number, the PCP will attempt to reach the member by mail. If the mail is returned, the PCP will document that the letter was returned.

h. Documentation:

1. The provider will enter member information on the pre-populated IHA Follow-Up form for each newly eligible member.

2. Information that will be documented will be:

a. Date member first contacted for IHA.

b. If a member schedules an appointment and fails to show, date failed appointment letter sent to member.

c. Date of second member contact.

d. Date of failed appointment if member fails to show again.

e. Comments documenting any other relative information.

f. Date of IHA, if performed.

3. The form will be returned to IPA when completed or at the end of the 120 days following date of member eligibility.

I. <u>For Health Plans that delegate the IHA process</u>:

1. IPA Responsibility:

a. The Member Services Department will send the PCP a member list by health plan. New members will be identified by date eligible (those that are new will have current month as date eligible).

b. IPA will send PCP copies of IHA Follow-Up forms pre-populated with members' name, address, and phone number. (see attached)

c. For plans that delegate the medical record review of IHAs, a quarterly random audit of the compliance with IHAs will occur. Monitoring will include verification of IHA performance for completeness and timeliness. For Medi-Cal members, the IHA review will include monitoring of timeliness of CHDP visits and follow up.

2. PCP Responsibility:

   a. On a monthly basis, the PCP will review their eligibility lists for new members.

   b. The PCP will contact the member to set up an appointment for an IHA, performing all age-appropriate services and education. A treatment plan and any interventions will be clearly documented.

   c. The PCP will document three (3) attempts to contact the member to set up an appointment. This may be done by contacting the member by telephone and/or sending an appointment card.

   d. If the member fails the scheduled appointment(s), two attempts to contact the member must be made. One attempt will be made by telephone using the number provided by the health plan and the second attempt will be in the form of mailing a missed appointment letter sent to the address provided by the health plan.

   e. The PCP will document all telephonic attempts to reach the member. If the mail is returned, the PCP will document returned letter.

   f. Documentation will include but is not limited to:

      1. Providers will complete the pre-populated IHA Follow-Up form for each newly eligible member.

      2. Information that will be documented will be:

         a. Date member first contacted for IHA.

         b. If a member schedules an appointment and fails to show, the PCP will document two attempts for follow up both telephonic and mailing the date failed appointment letter sent to member.

         c. Date of second member contact.

         d. If a member schedules an appointment and fails to show, the PCP will document two attempts for follow up both telephonic and mailing the date failed appointment letter sent to member.

         e. Comments documenting any other relative information.

         f. Date of IHA, if performed.

      3. Form will be returned to IPA when completed or at the end of 120 days after the date of member eligibility.

FORMS:

A. PM160 Claim Form
B. IHA Follow-Up Form
C. Missed Appointment Letters (Initial, Second Notice, Final)

REFERENCES:

A. American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Use
B. Individual contractual documents with contracted managed health care plans
C. DHCS Managed Medi-Cal Department Policy Letter 99-DRAFT
D. Guide to Clinical Preventive Services, a Report of the U.S. Preventive Services Task Force
E. Health and Safety Code
F. Title 17, California Code of Regulations, sections 6842-6852
G. Title 22, California Code of Regulations, sections 53851-53910.5

SUBJECT: Referral Tracking Process **Policy #:** UM25
DEPARTMENT: Utilization Management

Effective Date: October 17, 2003
Revision Date: March 14th, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To establish a mechanism to ensure that all referral activity is logged and followed up, ensuring timely access to care for all members.

POLICY:

All referrals will be tracked/logged by the PCP to ensure the following:

- Timeliness of referral activity
- Outcome of referral request
- Notification to members, including assistance with appointments.
- Compliance with appointment
- Receipt of Specialty/Provider findings
- Additional follow-up, as required.

The PCPs are responsible to ensure that the member receives an appointment for services as requested on the referral and ensure that the member keeps appointment. If the member does not keep the appointment, the PCPs will ensure that another appointment is made and document reason for member not keeping appointment.

The Member eligibility files, Initial Health Appointment (IHA) report, and Unused Referral report reminders and instructions are provided via notification and acknowledgement after login to the EHealthcare system. The PCP and office staff can access and download the Unused Referral report on the EHealthcare landing page for care coordination responsibilities. The PCP and office staff are responsible for reviewing the Unused authorization reports and following up with members to determine if the unused request is still needed.

If the referral service requested is no longer medically indicated or the member is refusing the referral service, the PCP will notify the UM Department. The UM Coordinator will also document the reason in the referral notes. If it is confirmed that the referral is no longer needed, the referral will then be closed by the UM Supervisor.

DEFINITIONS:

None required.

PROCEDURE:

A. PCP Responsibility:

1. The PCP will have a log or mechanism in place to follow the activity on all members being referred out for services. The IPA recommends the PCPs use the attached log, however if the PCP has a different log that covers all the same elements, they may use their own referral log process.

2. The PCP will work with the IPA UM Department, the Member, the Specialist/Provider, etc. to ensure completeness of referral process. Any areas not completed will be addressed and outcome reported to the UM Department.

B. UM Department Responsibility:

1. The UM Supervisor will receive a report from the Finance Department of all referrals marked "OPEN" on the IBNR Report. The UM Supervisor will then contact the PCP office to determine whether a member completed the specialty referral visit. If services are still needed, the expiration date may be extended.

2. All open activity will be documented and followed up.

FORMS:

Not applicable

REFERENCES:

Not applicable

SUBJECT: Comprehensive Perinatal Services Program (CPSP) and Comprehensive Perinatal Services **Policy #:** UM24

DEPARTMENT: Utilization Management

Effective Date:	June 20, 2001
Last Revision Date:	May 8th, 2024
Last Review:	January 2026

SCOPE:

This policy applies to the Medi-Cal and Commercial lines of business.

PURPOSE:

To ensure that all eligible pregnant and postpartum members receive services that meet the State Comprehensive Perinatal Services Program (CPSP) standards, and to establish a mechanism to refer pregnant and postpartum members to appropriate providers and to track, monitor, authorize and report the utilization of these services. NOTE: In Orange County, this program is referred to as Perinatal Support Services (PSS).

POLICY:

Pregnant members are to be provided services in accordance with the most recent standards of the American College of Obstetrics and Gynecology at a minimum. Pregnant members are to be provided comprehensive, multidisciplinary pregnancy and postpartum services including the following:

- Orientation to program at time of initial OB visit
- Initial Assessment and evaluation of risk factors
- Reassessments, in each trimester
- Postpartum Assessment
- Individualized care plan
- Interventions, if applicable, (i.e. Nutritionist, Psychosocial, etc.)
- Referrals, if applicable, (i.e. WIC, Genetic Screening, Dental Care, Family Planning, CHDP, Community Resources, etc.)
- Coordination of care, including documentation to PCPs medical record
- Resource list to service members local area

CPSP Assessments will be made utilizing the CPSP/ACOG assessment tools. Providers may obtain copies of the tools by contacting the Provider Services Department at HealthSmart MSO or by phone at (714) 947-8600.

Case coordination is the responsibility of the Obstetric provider, although the responsibility for care coordination may be delegated to a team member who is accountable to the physician.

Common pregnancy and postpartum conditions and issues for team discussion / interaction include areas of nutrition (N), psychosocial (PS) conditions and services, or health education (HE) are as follows:

- Unintended or unwanted pregnancy (PS)
- Teenage pregnancy (PS)
- Fear of physicians, hospitals and medical personnel (HE), (PS)
- Language barriers (HE)
- Lack of basic reproductive awareness (HE)
- Housing, food and transportation problems (PS)
- Multiple gestation (HE), (PS), (N)
- Personal and religious belief (HE)
- Need for bed rest during pregnancy (PS), (HE)
- Postpartum blues, depression (PS)
- Lack of basis parenting skills (HE)
- Sexual difficulty (HE)
- Sever Anemia (N)
- Financial problems (PS)

All members with any of the following list of conditions during pregnancy should be referred to specialty services:

- Diabetes
- Hypertension
- Hepatitis
- HIV Infection
- Genetic problems
- Epilepsy or neurological disorders
- Renal disease
- Alcohol or drug abuse
- Maternal cardiac disorders
- Thyroid and Endocrine disorders
- Family abuse
- Psychiatric problems

L.A. Care Covered Members:

Prenatal Care: IPA shall cover and ensure the provision of all Medically Necessary services for pregnant women. IPA shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

L.A. Care Covered – scheduled prenatal exams and the first post-partum follow-up consult are covered at no charge. Other prenatal benefits include:

- Prenatal supplements
- Diagnostic and genetic testing including but not limited to: Alpha-fetoprotein and screening for gestational diabetes.

Risk Assessment: IPA will implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the American College of Obstetrics and Gynecology standard (and additionally for Medi-Cal Members, the Comprehensive Perinatal Services Program (CPSP) standards per Title 22, CCR, Section 51348).

The results of this assessment will be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components.

The risk assessment tools shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

Referral to Specialists: IPA shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists and have access to genetic screen appropriate referrals. IPA will ensure that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services.

DEFINITIONS:

Not applicable

PROCEDURE:

1. Since members may self refer for OB care, no referral is needed for member to see an OB physician.

2. The provider will complete a pregnancy notification report (PNR) at the first OB visit.
3. A copy will be faxed to the IPA UM Department.

4. IPA UM Department will fax a copy of the PNR to those health plans requiring a copy.

5. The PNR will be forwarded to the Case Manager to log the OB case and member's participation in CPSP during their OB care and following delivery.

6. A log of the member's CPSP participation will be kept and reported to the health plans as part of Case Tracking and Monitoring. The tracking log may include but is not limited to, listing date offering of CPSP services, date of acceptance, date of refusal of CPSP services for all pregnant members.

7. If pregnant women decline CPSP services, Provider Organization practitioners have the women sign an Acknowledgement Form stating they were offered services and declined. Participation is voluntary.

8. Provider and/or staff will educate member regarding CPSP program. Each IPA and its contracted health plan have individual CPSP processes to assure that member receives services.
    a. IPA/Health Plan only utilizes CPSP certified providers.
        i. Services are offered to members at the time of the first visit.
        ii. If a member agrees, an initial assessment is performed by the office staff member designated as the CPSP coordinator.
        iii. Assessments are performed and documented. Reassessments are done each trimester following the trimester that the client entered care, and postpartum. Frequent and continuous assessment can identify new problems and areas of risk that should be addressed.
        iv. The OB provider will maintain a medical record using the appropriate Health Summary form, Initial Pregnancy Profile form, Perinatal Flow record, Perinatal counseling, and education form, CPSP Assessment form and Postpartum Assessment form. A copy of the OB record will be sent to the Primary Care Physician after completion of the postpartum exam.
        v. The Case Manager will assist the provider in the direction of member referral services and community services.
        vi. If a member refuses services, the physician or delegated team member will document the refusal in the OB notification form and in the member's chart.

    b. IPA/Health Plan has its own CPSP program for its members.
        i. Services are offered to members at the time of the first visit.
        ii. If a member agrees, an appointment is made with a CPSP coordinator, or an initial assessment is performed by the CPSP coordinator at the time of the visit.
        iii. Assessments are performed and documented. Forms are filed in medical record.
        iv. If a member refuses services, the physician or delegated team member will document the refusal in the OB notification form and in the member's chart and offer additional educational services.

    c. IPA/Health Plan utilizes a CPSP certified vendor to perform the service.
        i. IPA receives PNR, logs it into their OB tracking system, faxes a copy to those health plans requiring a copy and faxes a copy to the vendor.
        ii. The vendor contacts the member to offer services. At least 2 attempts are made to contact the member.
        iii. Appointments are scheduled for initial and follow-up assessments – the entire form is completed.
        iv. Documentation of assessments are sent to the physician and the IPA Case Manager for filing.
        v. If a member is identified with a high risk or delivers a high-risk baby (neonate), the mother will be referred to an appropriate subspecialty perinatal care facility.
        vi. If a member refuses services, or attempts at contacts fail, the physician is notified in writing (to be filed in medical record) and documentation is placed in the member's file.

9. All efforts will be made to address any language barrier issues by ensuring that the member is continuously offered / supplied interpreting services.

10. An evaluation of the IPA membership participation in CPSP will be made on a quarterly basis and reported to the UM Committee. Methods used to identify the use of CPSP providers/services may include authorization reports, claims reports, and/or use of Case Tracking and Monitoring system reports. Any requested intervention by the UM Committee will be logged into the UM activity and monthly status report given.

11. Identification of CPSP Certified Providers
    a. Begins at the time of initial contract when new OB-GYN providers are specifically asked to state whether or not they are CPSP Certified, and if so to produce documentation of their CPSP Certification status. This information is re-verified during the routine re-credentialing cycle.
    b. CPSP Certification status will be included information on IPA Provider Rosters sent to all Primary Care Physicians.
    c. CPSP Certification status will be included information in the Provider Demographics section of the Management Services Organization's computer system.

FORMS:

Pregnancy Notification Form (individual to each health plan)
Initial Combined Assessment (DHS 4455 (11/01))
Combined Assessment/Reassessment Tool (LA Public Health 1/98)
Combined Post Partum Reassessment (LA Public Health)
Individualized Care Plan (LA Public Health)

REFERENCES:

California Code of Regulations Title 22, Sections 51179, 51348, 51505
Comprehensive Perinatal Services Program Provider Handbook, 2005

SUBJECT: California Children's Services **Policy #:** UM23
DEPARTMENT: Utilization Management

Effective Date: June 20, 2001
Last Revision Date: April 1, 2019
Last Review: January 2024

SCOPE:

This policy applies to all Medi-Cal Programs, excluding CalOptima.

[Effective July 1, 2019, CalOptima in conjunction with the Health Network shall assume responsibility for authorization and payment of California Children's Services eligible medical services, including authorization activities, claims processing, case management quality oversight. See P&P UM45 for Whole Child Program details].

PURPOSE:

To ensure that all members who have California Children's Services (CCS) eligible medical conditions are appropriately identified and referred to local CCS providers for treatment.

To ensure that a coordinated effort of referring for CCS services occurs between the Primary Care Physician, the UM Department Case Managers and CCS Coordinators, CCS Providers and facility, CCS Case Manager, the member's assigned Health Plan Case Manager, and the member/guardian.

POLICY:

Members with a qualifying diagnosis will be referred to CCS for carve-out services related to their diagnosis.

The CCS program is open to members who are less than 21 years of age and a resident of California applying in their county of residence, that have a physical limitation or disease that is covered under the CCS condition list.

Members must meet the CCS financial eligibility requirements of Family income of less than $40,000 reported gross income or Family income of greater than $40,000 reported gross income, but out-of-pocket costs of care for the CCS eligible condition are expected to exceed 20% of the family's adjusted gross income. Most Medi-Cal eligible members automatically meets this requirement.

The PCP is responsible for providing a complete baseline health assessment and diagnostic evaluations to confirm or rule out a CCS eligible condition.

The PCP remains responsible for the complete health care of the member until CCS eligibility is determined.

If CCS eligibility is established, the CCS Program assumes case management responsibilities including prior authorization and payment for all services related to the CCS eligible condition. The PCP remains responsible for providing primary care services to the member, including coordination with CCS and other specialists to ensure continuity of care.

The Concurrent Review Nurses, Case Managers, UM Coordinators and CCS Coordinators will serve as a link between the Primary Care Physician and the CCS Program.

In order for a member to be accepted into the CCS Program, the member must meet medical eligibility and be referred to only contracted CCS providers and facilities. The IPA provider roster will list providers who are CCS contracted.

The Primary Care Physicians, Medical Director and / or UM Coordinators may identify potential CCS cases. For those cases that are questionable, the CCS Coordinator will contact a CCS Case Manager to discuss specific eligibility requirements. In some cases, the case may need to be reviewed by the CCS Medical Director to ensure eligibility. When further review is required, the CCS Coordinator will obtain all medical information necessary to assist in the review by the CCS Medical Director.

CCS services are covered only from the time the referral is made to the county CCS program, except for emergency services or services provided after hours. Referrals for emergency or after-hours care must be made to the county CCS program on the next business day and must include appropriate documentation justifying emergency or urgent care.

Referral to CCS is appropriate for, but not limited to, the following conditions:

Orthopedic – Congenital malformations; amputations resulting from disease or accident; infections of bone; progressive scoliosis; chronic disease of muscle and tendons

Central Nervous System: Paralysis from injury or infection; cerebral palsy' muscular dystrophy; atrophies; multiple sclerosis and parkinson's; spina bifida; severe epilepsy and controlled seizure disorders

Eye: Condition leading to loss of vision; chronic diseases such as glaucoma; cataract; retinal detachment; retrolental fibroplasias

Ear: Conditions leading to hearing loss; chronic or purulent otitis media with complications such as mastoiditis, perforation, cholesteatoma

Rheumatic or Congenital Heart Disease and Other Circulatory System Disease: Including cerebral vascular disease; diseases of arteries; arterioles, aneurysms; embolism; thrombosis; gangrene

Endocrine and Metabolic Diseases: Disease of the pancreas; pituitary; thyroid; diabetes; cystic fibrosis and rickets

Diseases of the Blood and Blood Forming Organs: Sickle cell; hemophilia; hemolytic and aplastic anemia

Diseases of the Digestive System: Atresia of the esophagus; diaphragmatic hernia; biliary atresia; cirrhosis of the liver; chronic ulcerative colitis

Diseases of the Respiratory System: Chronic lung disease; empyema; asthma with chronic lung disease; bronchopulmonary dysplasia

Diseases of the Genito-Urinary System: Severe glomerular nephritis; hemolytic uremic syndrome; congenital anomalies

PCP's, specialists, and Medical Group staff should appropriately refer potentially eligible children to CCS within 24 hours of identification and should inform the parent or legal guardian of the referral to the CCS Program.

The CCS Coordinator will maintain an updated resource list and "Overview of CCS Medically Eligible Conditions". All updates will be disseminated as received from the CCS agencies, health plans, etc., to all providers and staff.

The CCS Coordinator will maintain an ongoing log of all cases with CCS activity. This log will be forwarded to the contracted health plans on a monthly basis as part of the UM Reporting process.

All providers, and staff will be in-serviced on the general conditions that meet eligibility for CCS coverage.

The Primary Care Physician and Medical Directors may request an appeal of any case that is denied by CCS by doing so in writing. The CCS Coordinator and Case Managers will assist and coordinate this process.

DEFINITIONS:

California Children's Services (CCS) is a carved-out program that provides physical habilitation and rehabilitation for children with specific conditions. CCS sets forth the eligible specific conditions and guidelines for coverage of the condition. The goal is to obtain the medical and allied services necessary to achieve maximum physical and social function for children meeting these specific conditions. In most cases, the maximum age for eligibility is 21 years old.

Although the Healthy Families Program coverage stops at age 18, some exceptions may be made to cover a member on CCS until age 21.

CCS services are a "carve-out" under a Managed Care program, but the member remains enrolled with the health plan and IPA for the purposes of receiving primary care and services unrelated to the CCS condition(s). The responsibility for paying for treatment services for the CCS eligible condition of the child who is enrolled in managed care rests with CCS as opposed to the IPA.

PROCEDURE:

A. All referral requests initially screened by the UM Coordinator that appear to fall within the categories of medical eligibility for CCS will be coded as a potential CCS medically eligible case.

B. The referral will be processed through the usual UM Authorization process and will be reviewed by the Medical Director who will assess potential CCS medical eligibility. If the Medical Director determines the case does not meet CCS medical eligibility, the referral will be coded as a standard request and processed.

C. If the referral appears to meet potential CCS medical eligibility, the case will be approved to the CCS provider and copied to the CCS Coordinator to ensure coordination of coverage by CCS within 24 hours.

D. The CCS Coordinator will contact CCS to determine if the case is currently authorized. In Orange County, this may be done by accessing the Child Watch System, where available. If no current information is on file, the CCS Coordinator will contact the Primary Care Physician to initiate the CCS application / referral process.

E. Referral Process

1. The provider or parent may complete a CCS form or write a letter containing the following information:
    a. Patient's name
    b. Patient's date of birth
    c. Name, address, and telephone number of the parent or legal guardian
    d. Medical condition
    e. Name, address and telephone number of the referral source

2. Referrals to CCS from providers or acute facilities should include:

    a. A completed CCS program referral form
    b. Medical history with sufficient medical information to confirm that a CCS eligible condition exists
    c. Description of services being requested
    d. Name of CCS paneled provider who will provide the requested services (if known)
    e. Name and telephone number of the referral source
    f. Completed CCS program application if available at the physician's office at the time of the referral

3. Upon referral, the CCS program determines whether there is a medically eligible condition, whether the family is financially eligible, and whether the child is a resident of the county in which he or she has applied for service. If the child is determined to be eligible for the program the client, parent, or legal guardian signs a CCS program agreement.

    a. The program agreement indicates the family's willingness to abide by CCS program policies and procedures and offer recipients the full range of CCS program benefits (similar to a consent form).
    b. Upon receipt of a request for services, the CCS program reviews the request and makes the determination of medical necessity and appropriateness. All services except for emergency services and after-hour services require prior authorization. If a request is found to be medically necessary for the treatment of the CCS eligible condition or for the treatment of an associated or complicating condition, the CCS program issues an authorization.
    c. CCS sends an authorization to the CCS paneled provider indicating that he or she can deliver approved medically necessary and appropriate services for the treatment of the client's CCS eligible condition. The CCS paneled provider will be reimbursed at a fee-for-service rate. Separate authorization must be obtained for each hospitalization.

F. The CCS Coordinator will make daily / weekly calls to the CCS Case Manager to obtain a CCS Registry number and Authorization number.

G. The CCS Coordinator will attempt to obtain a treatment plan from the CCS Physician, which will be forwarded to the Primary Care Physician and the Case Managers for further coordination.

H. In order to prevent a delay service to the member, all potential CCS eligible referrals that are approved by the IPA's Medical Director are processed as approved with a statement that the case is potentially CCS medical eligible. Coverage for these services will be paid by the IPA if found not to be medically eligible by CCS, otherwise the provider is directed to the appropriate CCS agency to obtain coverage for the services provided.

I. All referrals coded CCS in the IS system are flagged to alert the claims department of potential coordination of coverage by CCS.

J. All planned inpatient stays that may meet potential CCS medical eligibility will be referred to contracted CCS facilities and will be referred to CCS within 24 hours.

- Effective July 2013, if CCS covers the first day of an admission, the group is no longer financially responsible for the admission. If CCS does not cover the entire admission, the non-covered days are the responsibility of Medi-Cal direct.

K. Emergency Admissions that meet CCS medical eligibility will be coordinated through the facility Case Manager and the Concurrent Review Nurse. The facility will be advised to make the CCS referral for coverage. The CCS Coordinator will make daily contact to ensure authorization was obtained.

L. Logs of CCS activity will be sent to the contracted health plans through the monthly UM reporting process and will include the following information:

1. Member information
2. Date case opened/identified
3. Primary Care Physician
4. Provider, including Specialty / Facility referred
5. Diagnosis and Services Requested
6. CCS Case Status
7. CCS Registry and Authorization number
8. IPA tracking number
9. Dates / Length of Coverage

FORMS:

Not applicable

REFERENCES:

Title 22, California Code of Regulations

SUBJECT: Linked Program Service Referrals **Policy #:** UM22
DEPARTMENT: Utilization Management

Effective Date: July 16, 2000
Last Revision Date: February 6th, 2025
Last Review: February 2026

SCOPE:
This policy applies to all lines of business.

PURPOSE:
To ensure eligible recipients are given information regarding availability of special services and state program services, and to provide a mechanism for documentation of member referrals to these special service programs, which does not fall under the usual Referral Authorization process.

To ensure member access to culturally appropriate services.

POLICY:

Annually, the UM and CM staff will review the various Linked Program Referrals and other social services to the member's care. To ensure appropriate identification and referrals to Linked Program Services, annually Providers and UM/CM Staff are educated on the individual linked programs and the criteria for enrollment/participation in each program.

In all cases referred to Linked Program Services, it is the responsibility of the Primary Care Physician to collaborate with and coordinate care with the provider of the Linked Program Service. Case Management Nurses, Personal Care Coordinator (PCC) and/or UM Coordinators will collaborate with the health plan designated contact for coordination of referral to services that are the plan's financial responsibility.

As part of the Initial Health Assessment of a member and/or as a result of the Staying Healthy Assessment of a member, the Primary Care Physician may refer a member to a Linked Program Service.

In all cases referred to Linked Program Services, it is the responsibility of the Primary Care Physician to notify the member/family of the referral to Linked Program Services and to notify the IPA of the Linked Program Services provided.

In addition to the IPA providing services for all aspects of care, resources are available through special services and state programs. IPA providers may utilize these services only when care or services are needed that cannot be provided by the IPA.

The Primary Care Physicians will document in the member's medical record all referrals to Linked Program Services. Members may be required to meet eligibility requirements for the individual program.

In some cases, the Linked Program Service is not the financial responsibility of the medical group, however ensuring the medically and culturally appropriate programs are offered to the members is the Primary Care Physician's responsibility. The Primary Care Physician may refer these cases to Case Management for monitoring.

Specifically, for Medi-Cal members under the age of 21, the IPA is required to provide and cover all medically necessary services **with the following exceptions**:

- Dental services provided by dental personnel covered by the Medi-Cal Denti-Cal program (Policy Letter 13-002).
- Non-medical services provided by Regional Centers to individuals with developmental disabilities, including but not limited to, respite, out-of-home placement, and supportive living. However, MCPs must monitor and coordinate all medical services with Regional Center staff.
- Alcohol and substance use disorder treatment services available under the Drug Medi-Cal Program and outpatient heroin detoxification services, including all medications used for treatment of alcohol and substance use disorder covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through Medi-Cal fee-for-service (FFS).
- Specialty mental health services listed in Title 9, CCR, Section 1810.247 for beneficiaries that meet medical necessity criteria as specified in Title 9, CCR, Sections 1820.205, 1830.205, or 1830.210, which must be provided by a mental health plan (APLs 13-018 and 13-021).
- CCS eligible and approved services.

The PCP will continue to provide all medical primary care services for any member enrolled or participating in a Linked and/or Carve out program.

DEFINITIONS OF LINKED PROGRAMS:

ALCOHOL/DRUG ABUSE: County programs for members requiring specialty and inpatient chemical dependency/substance abuse treatment and services, including detoxification. This includes, but is not limited to, outpatient heroin detoxification services. Criteria for eligibility includes members with history of drug, alcohol and/or substance abuse.

CHDP: The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low-income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts.

CSHCN: Defined as services for those members who have or are at risk for chronic, physical, behavioral, developmental, or emotional conditions and who require health or related services of a type or amount beyond that required by children generally. Service referrals for these members may include but are not limited to CCS, Regional Center, EPSDT programs, etc. Case Management cases may be opened, and care coordinated with the various programs.

COMMUNITY BASED ADULT SERVICES [CBAS]: Effective April 2012, this program replaced the prior Adult Day Health Care [ADHC] program for providing services to older persons and adults with chronic medical, cognitive, or mental health conditions and/or disabilities that are at risk of needing institutional care. This program has more stringent eligibility standards than the prior ADHC program and CBAS providers must maintain an ADHC license. The primary objective of the program is to restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and delay or prevent inappropriate or personally undesirable institutionalization. The program stresses partnership with participants, family and/or caregivers, the Primary Care Physician, and the community in working toward maintaining personal independence. Services include professional nursing, social services and/or personal care services, therapeutic activities and one meal per day. Additional services may include Physical Therapy, Occupational Therapy, Speech Therapy,

Mental Health Services, Dietary services, and transportation to and from the center. Criteria for eligibility include but is not limited to members who meet NFA level of care; members diagnosed with an organic acquired brain injury or chronic mental illness; members with moderate to severe Alzheimer or dementia and/or mild cognitive impairment; and/or members with developmental disabilities meeting criteria for Regional Center eligibility.

DENTAL SERVICES: All children over the age of 3 should have the benefit of dental diagnosis and remedial treatment and should be seen by a dentist at least annually.

DDS HCBS: The Department of Developmental Services administered Home Community Based Services Waiver Program is to ensure that the medical needs of developmentally disabled Medi-Cal recipients aged 21 and under are met appropriately and safely. Regional Centers oversee this program.

EARLY/HEAD START PROGRAMS: The Early Start program provides early intervention services to infants and toddlers from birth to 36 months who have significant developmental delay, presence of a diagnosed condition known to result in developmental disability, or who are high risk from a combination of biomedical factors. Referrals for these services are sometimes coordinated through the Regional Center.

The Head Start Program is for members from ages 3-5 for education and health assessment. Referrals for these services may be coordinated through the Local School System.

EPSDT: Early and Periodic Screening, Diagnosis and Treatment services to eligible members under the age of 21 for comprehensive case management services related to medical, social, educational, and other services. Types of services: Case management, Cochlear implants, home nursing, Psychology, Occupational therapy, Audiology, Orthodontics, Hearing Aids, Mental Health Evaluation and services, medical nutrition services assessment and therapy, Pharmacy, Physical Therapy, Pulse oximeters and Speech therapy. This service is part of the Regional Centers process.

HIV/AIDS: The AIDS Waiver Program provides home and community-based services for persons with AIDS or symptomatic HIV Disease as an alternative to institutionalized care.

LONG TERM SUPPORT SERVICES [LTSS]: Plans work in partnership with consumers and advocates, providers, and others to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have a choice, control, and access to a full array of quality services that assures optimal outcomes, independence, health, and quality of life. The goals of LTSS are to provide an alternative to institutional placement, seamless delivery, physical and programmatic accessibility, member centered care coordination and integration with medical and behavioral health. These services may include a Multipurpose Senior Service Program [MSSP], Long Term Care [LTC], Community Based Adult Services [CBAS], In-Home Support Services [IHSS] and/or Home and Community-Based Services [HCBS]. These services include but are not limited to: Supplemental personal care services, Supplemental chores, supplemental protective services, In home skilled nursing care and therapies services for chronic conditions, Respite Care (in home or out of home), Nutritional supplements and home delivered meals.

To be eligible for IHSS, the member must be a citizen of the United States or a qualified alien and a California resident. The member must live in own home (acute care hospital, long-term care facilities, and licensed community care facilities are not considered "own home"). The member's personal property and assets are evaluated in determining eligibility.

To be eligible for MSSP, the member must be 65 years of age or older; live in the MSSP service area; eligible for Medi-Cal and be certified for nursing home placement.

To be newly eligible for Long Term Care, members must meet Medi-Cal Skilled Nursing program admission requirements.

MENTAL HEALTH: Psychiatric outpatient and inpatient services for diagnosis, treatment, and consultation regarding management of severely emotional issues. This may also include testing for clarification of diagnosis or to establish a treatment plan.

REGIONAL CENTERS: Provide overall case coordination for eligible consumers and their families to assure access to health, developmental, social, educational, and vocational services. Services are provided on a case-by-case basis, taking into consideration the availability of generic services appropriate to the consumers' needs. To be eligible for services, a person must have a disability that begins before the person's 18th birthday, be expected to continue indefinitely and present a substantial disability as defined in *Section 4512* of the *California Welfare and Institutions Code*. Eligibility is established through diagnosis and assessment performed by

STD: Services include education, prevention, screening, counseling, diagnosis, and treatment of members with Sexually Transmitted Infections. These are referrals to the Local Health Department.

SENSITIVE SERVICES MINOR & ADULTS: Confidential referrals to Local Health Department for those services related to sexual assault, drug and/or alcohol abuse, pregnancy, family planning and sexually transmitted infections for children 12 years of age or older and Adults. Members 12 years of age and older may sign an Authorization for Treatment form for any sensitive services without parental consent.

TB: The TB Control Program was established to control the spread of Tuberculosis working with the Local Health Department to achieve optimum clinical outcomes for all members identified as known or suspected cases of TB.

W.I.C.: A special supplemental nutrition program for Woman, Infants and Children provides nutritional education and specific foods for women, infants, and children with low incomes.

PROCEDURE:

A. On a quarterly basis, the Primary Care Physicians will receive a listing of all resource services and rosters of contracted providers.

B. The Primary Care Physician may use the Referral Authorization Worksheet or Direct Access Referral to refer members for services that require an authorization. In the cases where the service the member is being referred to is not the financial responsibility of the IPA, the information will be logged for tracking purposes and in some cases, forwarded to Case Management for follow up.

C. If the Primary Care Physician chooses not to use the UM Referral process to refer the member, a log will be kept of all members referred for Linked Program Services. This log must be submitted to the UM Department by the 5th of each month.

D. The Primary Care Physician may be required to fill out special forms, providing documentation, for the initial referral to the Linked Program and any follow up service.

E. Members receiving services from In-Home Medical Care Waiver Program, Home and Community-Based Services, Long Term Care, Major Organ Transplants, other than Kidney, Multipurpose Senior Services Waiver Program – Disciplinary Senior Services Program and Skilled Nursing Facility Waiver Program, may be required to disenroll from their health plan. If required by the Health Plan, the IPA will work with members to refer them to their health plan's Member Services Department for assistance with Disenrollment.

F. The UM Department will track all Linked Program referrals. Monthly the UM Department will submit, to the individual contracted health plans, the log of all members who were referred for Linked Program Services.

G. Instructions for Referral:

1. ACUPUNCTURE:
   Depending upon the member's assigned health plan, this may be a Carve Out service. For further directions on referring to these services, contact the UM Department.

2. ACUTE OR SUB-ACUTE CARE FACILITIES:
   Contact the IPA Utilization Department for a listing of, and assistance with, referral to an acute or sub-acute care facility.

3. COMMUNITY BASED ADULT SERVICES [CBAS]: [Formerly known as Adult Day Care Health]: This is a Carve Out program. You may contact the Case Management Department for direction and assistance in referring members to these programs. Members and family members may also receive assistance from their Social Worker for programs available. Eligibility for the program will be coordinated with the members assigned health plan.

4. ALCOHOL/DRUG ABUSE:
   The Primary Care Physician will identify individuals requiring alcohol and or substance abuse treatment services and arrange for their referral to the Alcohol and Other Drugs Program, including outpatient heroin detoxification providers, for appropriate services. The PCP will assist Members in locating available treatment service sites. To the extent that treatment slots are not available in the Alcohol and Other Drugs Program within the Plan's Service Area, the PCP or the UM Coordinator shall contact the health plan to pursue placement outside the area. The IPA shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment and coordinate services between the primary care providers and the treatment programs.

   Call the county contact number for treatment centers.

   Los Angeles County Contact Number: (626) 299-4193 or (800) 564-6600

   Orange County Contact Number: (714) 834-6032

5. CHDP: services are provided in accordance with the most current CHDP standards. [See periodicity tool]

   Identification of CHDP Certified Providers
   a. Begins at the time of initial contract when new providers are specifically asked to state whether or not they are CHDP Certified, and if so to produce documentation of their CHDP Certification status. This information is re-verified during the routine re-credentialing cycle.
   b. CHDP Certification status will include information on IPA Provider Rosters sent to all Primary Care Physicians.
   c. CHDP Certification status will be included information in the Provider Demographics section of the Management Services Organization's computer system.

   The PCP will maintain the "medical home" and ensure the overall coordination of case and case management of members who obtain CHDP services through the local school districts or school sites.

   All children should receive necessary immunizations at the time of any health care visit in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatric (AAP) periodicity tables.

   For information on becoming a CHDP provider and/or information regarding the program, call:

   Los Angeles County: 626-569-9350 or 800-993-2437

   Orange County: (714) 834-8665

6. CCS: (See P&P UM23 CCS – California Children Services)
   This is a Carve Out program. Contact the CCS Case Manager for direction and assistance with referrals for members with CCS eligible conditions to be referred.

7. CHIROPRACTIC SERVICES:
   Depending upon the member's assigned health plan, this may be a Carve Out service. For further directions on referring to these services, contact the UM Department.

8. DENTAL SERVICES:
   Dental screenings for all Members are included as part of the initial health assessment.
   For Members under twenty-one (21) years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age 3 or earlier if conditions warrant.

The IPA may require prior authorization for medical services in support of dental procedures. This may include anesthesia services for inpatient and outpatient services per Health Plan contractual agreements. Some health plans do not require prior authorization for dental anesthesia. Members must not be unduly delayed due to the authorization process.

Medi-Cal members are entitled to dental services under IV sedation or general anesthesia when medically necessary in an appropriate setting such as:

a) Hospital,
b) Accredited Ambulatory Surgical Center,
c) Dental office; or
d) Community Clinic that:
    i) Accepts Medi-Cal dental program.
    ii) Is a Non-profit organization; and
    iii) Is recognized by the Department of Health Care Services as a licensed community clinic or a Federally Qualified Health Center [FQHC] or FQHC look-alike.

Medical Services not covered by a Dentist or Dental Anesthesiologist are covered by the member's medical benefit and include associated prescription drugs, laboratory services and pre-op exams.

Providers shall adhere to all regulatory requirements for pre-operative and perioperative care, monitoring and equipment requirements, emergencies and transfers and monitoring guidelines.

Authorization for general anesthesia provided by a physician anesthesiologist during an inpatient stay is covered by the inpatient authorization.

Criteria for Intravenous Sedation or General Anesthesia:
Behavioral modification and local anesthesia shall be attempted first, conscious sedation shall then be considered if this fails or is not feasible based on the medical needs of the member.

If sedation is indicated, the least profound procedure shall be attempted first. The use of local anesthesia and the use of conscious sedation must have failed or is not feasible with the medical needs of the member before consideration of IV Sedation or general anesthesia. In addition, any one of the following would be an indication for IV or general anesthesia:

a) Use of effective communication techniques and the inability for immobilization [patient may be a danger to self or staff] failed or was not feasible due to the medical needs of the member.
b) Member requires extensive dental restoration or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
c) Member has acute situational anxiety due to immature cognitive functioning.
d) Member is uncooperative due to certain physical or mental compromising condition.

Members with certain medical conditions such as but not limited to moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmia, and significant bleeding disorders [i.e., on Coumadin therapy] should be treated in a hospital setting or a license facility capable of responding in a serious medical crisis.

Members will be referred to the following dental providers:

For Medi-Cal:
Services are provided through Denti-Cal.
For information call: (800) 322-6384

L.A. Care Covered and L.A. Care Covered Direct

Dental Services for Adult Members Aged 21 and Older: (Medi-Cal only)

The following covered benefits include:
1) Exams and x-rays
2) Cleanings
3) Fluoride treatments
4) Fillings
5) Anterior root canals (front teeth)
6) Prefabricated crowns
7) Full dentures
8) Other medically necessary dental services

L.A. Care covers dental and orthodontic services for children up to the age of 19. L.A. Care does not cover adults, except for certain circumstances.

Pediatric Coverage: Children up to the age of 19 can receive dental and orthodontic services from Liberty Dental providers. The level of dental services covered range from preventive and basic care like cleanings and fluoride treatments to some major services, such as root canals and extractions. For more information on the services covered and assistance locating participating providers, members can contact Liberty Dental at 1-888-700-5243 (TTY/TDD 1-877-855-8039).

Adult Coverage: Adults are not covered for basic, preventive, major dental services, or orthodontic care. Adults may be eligible for dental services following accidental injury to teeth and dental services resulting from medical treatment, such as surgery on the jawbone and radiation treatment. Members are advised to review the Evidence of Coverage (Member Handbook) for important information about dental coverage offered by your plan with L.A. Care Covered™ or L.A. Care Covered Direct™ or call Member Services at 1-855-270-2327 (TTY/TDD 711) for more details.

Long Term Care: Long-term skilled nursing care in a licensed facility, and respite care is Excluded from L.A. Care Covered Contract. Short Term Care: Inpatient Medically Necessary skilled nursing Services including Subacute Care Up to a maximum of 100 days per Member, per Calendar Year, maximum except when received through a Hospice Program provided by a Participating Hospice Agency. This day maximum is a combined Benefit maximum for all Skilled nursing services whether rendered in a Hospital or a free-standing Skilled Nursing Facility.

9. DDS HCBS:
For information contact the Regional Center in the member's area.

10. ESRD – End Stage Renal Disease:
When members are diagnosed with End Stage Renal Disease and the member begins dialysis treatment, the UM Staff and/or Case Manager will follow the health plan DOFR for coordination of

Dialysis Services. With some plans, the case will immediately be immediately co-coordinated with the plan. The Case manager and/or UM Staff will obtain a copy of the 2728 form which certifies the member to begin dialysis.

11. HEALTH DEPARTMENT

Los Angeles County:
1313 N. Figueroa St
Los Angeles, CA 90012
http://www.dhs.co.la.ca.us/

Orange County: (714) 834-4722

Health Care Agency
PO Box 355
Santa Ana, CA 92702

12. HOSPICE SERVICES:

Services shall be limited to individuals who have been certified by a Medical Doctor as terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course and who directly or through their representative voluntarily elect to receive such benefits in lieu of other care as specified.

Authorization for hospice services either by the plan or by the IPA will cover a certification period of two 90-day periods and an unlimited number of 60-day periods and must be to a Medicare certified provider. Covered hospice services must be available on a 24-hour basis to meet the needs of the member's care, to manage terminal illness and any related conditions. In some cases, Hospice services may be authorized by the health plan. All Hospice cases will be referred to Case Management.
Hospice can start or continue in a home or clinical setting including a SNF or Intermediate Care Facility. Changes in setting will be coordinated by the Hospice provider.

Members have the right to a signed statement with the Hospice revoking the election of services at any time.

For a member under the age of 21, a voluntary election of hospice care shall not constitute a Waiver of any rights of that member to be provided with, or to have payment made for covered services that are related to the treatment of the member's condition for which a diagnosis of terminal illness has been made.

An interdisciplinary team of medical, social, and spiritual will ensure an appropriate written plan of care is in place. Hospice services are to be provided to the extent reasonable and necessary for palliation and management of the terminal illness such as pharmaceuticals, PT, OT, ST and DME. Hospice services include but are not limited to skilled nursing services, certified home health aid services, homemaker services, dietary counseling from a qualified provider. Bereavement services are available to the family for at least one year after death.

For Hospice, a "Period of Crisis" is defined as continuous coverage to achieve palliation or management of acute medical symptoms. "Respite Care" is short term inpatient care provided when necessary to relieve care givers and is limited to an occasional basis and no more than 5 days at a

time. Coverage for Hospice services may differ between health plans and lines of business and will be verified at the time of the request.

For members who elect to receive hospice, IPA will arrange for continuity of medical care, including maintaining-provider relationship for established patient. IPA assigns and trains a representative to facilitate and coordinate the management of hospice SNF admissions with the hospice provider. Admission to a nursing facility of a member who has elected covered hospice services does not affect the Member's eligibility coverage. Hospice services are not long-term care services regardless of the member's expected or actual length of stay in a nursing facility.

13. END OF LIFE OPTION ACT:

Assembly Bill (AB) X2-15 End of Life Option Act became effective on June 9, 2016, and allows terminally ill beneficiaries ages 18 and older, with the capacity to make medical decisions, to be prescribed aid-in-dying medication if certain conditions are met. Provision of these services by health care providers is voluntary, and refusal to provide these services does not place the physicians at risk for civil, criminal, or professional penalties.

These services will be covered by Medi-Cal fee-for-service and are carved out from Medi-Cal managed care plans. Providers may direct members to contact the Medi-Cal customer service center at 1-800-541-5555 for additional information about End-of-Life services, including coverage inquiries and directory assistance in locating Medi-Cal fee-for-service physicians.

During an unrelated visit with a physician, a member may provide an oral request for EOL services. If the physician is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that physician may elect to become the members attending physician as he or she proceeds through the steps in obtaining EOL services. EOL services following the initial visit are no longer the responsibility of the group and must be completed by a Medi-Cal FFS attending physician, or a Medi-Cal FFS consulting physician. Alternatively, if the physician is not a Medi-Cal FFS provider, the physician may document the oral request in his or her medical records as part of the visit. The physician should advise the member that following the initial visit he or she must select a Medi-Cal FFS physician in order for all of the remaining requirements to be satisfied.
If the service is a benefit of the member's health plan but the group is not delegated the request will be forwarded to the health plan.

14. EARLY START PROGRAM:

Referrals for these services are sometimes coordinated through the Regional Center for children who may be eligible to receive services from the Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. PPG shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program.

PPG shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment service identified in the

individual family service plan developed by the Early Start program, with Primary Care Provider participation.

15. EPSDT:

IPA's are required to cover and ensure the provision of screening, vision, dental, hearing, preventive, and medically necessary diagnostic and treatment services for individuals under the age of 21 including EPSDT Supplemental Services as well as such other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan unless otherwise carved out of the plan's contract, regardless of whether such services are covered under California's Medicaid State Plan for adults. The EPSDT benefit includes case management and targeted case management services designed to assist children in gaining access to necessary medical, social, educational, and other services.

For Members meeting eligibility for EPSDT services, the Primary Care Physician will ensure the member and their parents or guardians know what services are available and have access to the health care resources they need and will arrange EPSDT supplement services.

The IPA is responsible for these services when not covered under CCS or service provided by the Regional Center benefit.

Members may be referred to Case Management for monitoring the coordination of care provided including but not limited to all medically necessary services delivered both within and outside the IPA's provider network. The Case Manager may also provide assistance with appointments and transportation services, including medical and non-medical transportation services, and the conditions under which non-medical transportation is available for medically necessary services that are covered by the IPA.

Where another entity, such as a local education agency (LEA), Regional Center, or local government health program, has overlapping responsibility for providing services to an individual under the age of 21, the Case Manager along with the PCP will evaluate what level of medically necessary services the individual requires, determine what level of service (if any) is being provided by other entities, and then coordinate the provision of services with the other entities to ensure that other entities are not providing duplicative services.

Private Duty Nurse (PDN) Case Management Responsibilities-EPSDT-Basic Case Management**.**
When not delegated, the group will coordinate with the member's plan to obtain these services.

When an eligible member under the age of 21 is approved for PDN services, case management services will be provided. Case Management services will be initiated if a member requests assistance prior to the approval of services. Case Manager responsibilities include but is not limited to:

1. Case coordination with the CCS Case Manager to assess PDN service approval for members with CCS eligible conditions.
2. Providing the member with information about the number of PDN hours the member is approved to receive.
3. Contacting enrolled Home Health Agency [HHA] and enrolled individual nurse providers to seek approved PDN services on behalf of the member.

4. Identifying potentially eligible HHAs and individual nurse providers and assisting them with navigating the process of enrolling to become a Medi-Cal provider; and
5. Working with enrolled HHAs and enrolled individual nurse providers to jointly provide PDN services to members.
6. Case will be tracked and monitored for additional coordination.

For information call the Regional Center in the member's area.

16. HIV/AIDS:
Medi-Cal beneficiaries enrolled in Medi-Cal managed care health plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Waiver Program and enrollment is dependent on available space.

Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Waiver Program and enrollment is dependent on available space. Persons already enrolled in the HIV/AIDS Home and Community Based Services Waiver Program may voluntarily enroll in a Medi-Cal managed care health plan.

Referrals for outpatient office visits will be made within 2 days of identification.

Orange County:
HIV Test Information – (714) 834-8129

Los Angeles
HIV Help Desk – (213) 351-8516

17. LHD
See Health Department

18. LOCAL EDUCATION AGENCY ASSESSMENT SERVICES – LEA:
These programs include Early Start and Head Start. The Early Start Program may be referred through the Regional Center. Head Start services are usually referred through the State School Programs. For further directions, you may contact the Case Management Department or direct the member to their Social Worker.

19. LEAD POISIONING CASE MANAGEMENT:
See Health Department

20. LONG TERM CARE:
    Long Term Care (LTC) is defined as care in a facility for longer than the month of admission plus one month. The IPA shall cover Medically Necessary nursing care provided from the time of admission and up to one month after the month of admission. Members who are admitted into a SNF will remain enrolled in managed care instead of being disenrolled and enrolled in fee-for service Medi-Cal.

21. LONG TERM SUPPORT SERVICES:
    For referrals to the plans Long Term Support Services, the UM Coordinator or Case Management Nurse will contact the health plan's designated contact for review of case and eligibility for service.

22. MENTAL HEALTH:
    Contact IPA Provider Services for information - See P&P UM 18 and UM 27

23. PRAYER & SPIRITUAL HEALING:
    This is a Carve Out service. You may contact the Case Management Department for direction and assistance in referring members to these programs. Members and family members may also receive assistance from their Social Worker for programs available.

24. REGIONAL CENTER:
    The PCP will refer Members with developmental disabilities to a Regional Center for the evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placements, and supportive living. The PCP will participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

    For information regarding services call:

    Regional Center of Orange County – (714) 796-5100

    Regional Center (Alhambra, E. LA, Northeast LA, Whittier): (213) 224-4700

    Regional Center (Bellflower, Torrance, Harbor, Long Beach: (213) 540-1711

    Regional Center (Central LA, Glendale, Hollywood-Wilshire, Pasadena) (213) 383-1300

    Regional Center (Compton, San Antonio, South LA, SE LA, SW LA): (213) 734-1884

    Regional Center (East Valley, San Fernando, West Valley): (818) 997-1311

    Regional Center (El Monte, Monrovia, Pomona, Glendora) – (818) 814-8811

    Regional Center (Inglewood, Santa Monica-West) – (213) 337-1155

22. STD:

IPA PCP or OB/Gyn provider
Orange County
STD Clinic Information - (714) 834-8592

23. SENSITIVE SERVICES MINOR & ADULTS:

Contact the local health department for referrals.

24. TB/DOT:

TB care and treatment is provided in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention. PCPs and Case Managers will coordinate with Local Health Departments in the provision of **Direct Observed Therapy** as required, however these are Carved Out services.

The PCP shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy. The following group of individuals area at risk for non-compliance for the treatment of TB:

- Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); members whose treatment has failed or who have relapses after completing a prior regimen; children and adolescents; and individuals who have demonstrated noncompliance (those who failed to keep office appointments).

- In addition, the PCP shall assess the following groups of members for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of the Delegate's providers, a Member with one or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

Members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

For Los Angeles County (213) 744-6160

For Orange County: (714) 834-8027

25. VISION:

Depending upon the member's assigned health plan, vision services for refraction and/or coverage for corrective lenses may be a Carve Out service. For further direction on referring for these services, contact the UM Department which will be provided according to the member's plan benefit.

When not delegation for Vision services, the group will not automatically deny requests as a "carve out service", rather the Provider and Member will be redirected.

For members with Medi-Cal coverage, when delegated for Vision services for refraction, the provider will arrange for fabrication of optical lenses through the Prison Industry Authority [PIA] optical laboratories. The group is responsible for the vision exam and the dispensing of the lenses.

- Effective January 1, 2020, coverage for eyeglasses (frame and lenses) for eligible adult beneficiaries ages 21 or older is reinstated.

Even if the benefit for eye examination covers the member once every two (2) years, Title 22 states, "A second eye examination within 24 months is covered when a sign or symptom indicates a need for this service. The provider of services shall make a reasonable effort to ascertain the date prior to any examination with refraction".

For members with coverage under Covered California, the group will follow the member's health plan benefit coverage requirements for vision care.

- For example, LA Care covers vision care benefits for members up to the age of 19. The benefit covers refraction exam [including dilation], 1 pair of prescription glasses per year or contacts and medically necessary contact lenses coverage for the treatment of keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism and is provided through VSP. The annual deductible is waived.

26. WAIVER PROGRAMS:

As part of discharge planning and upon identification at any other time, members who may benefit from HCBC Waiver Programs will be referred to the Health Plan's Case Management Department for In-Home Medical Care Waiver, Nursing Facility Subacute Waiver, and Nursing Facility A/B Waiver. Members with developmental disabilities eligible for Home and Community -Based Services (HCBS) Waivers will be referred for services and the service provided will be documented in the members' medical record. The IPA is responsible for ensuring the orderly transfer of the members to the Medi-Cal Fee-For-Service program. If the member does not meet the criteria for the Waiver Program, or if placement is not available, the IPA shall cover all medically necessary services to the member.

27. W.I.C.:

The PCP will refer eligible members to the WIC program with a current hemoglobin or hematocrit laboratory value. WIC referrals will be considered as part of its initial health assessment of members, or, as part of the initial evaluation of newly pregnant women. The PCP will document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program.

For information regarding referrals call: 1-888-942-9675

FORMS:

Referral Authorization Worksheet

REFERENCES:

[CA Health & Safety Code, Sections 123800-123995; State Department of Health Services (DHCS) Agreement No. 04-36069, Exhibit A, Attachment 11, Comprehensive Case Management Including Coordination of Care Services]

APL 22-018 Skilled Nursing Facilities -Long Term Care Benefit

APL-23-005 Early and Periodic Screening, Diagnostic and Treatment Services for Medi-Cal members under the age of 21.

End of Life (EOL) Services (APL16-006)

SUBJECT: Second Medical Opinion **Policy #:** UM20
DEPARTMENT: Utilization Management

Effective Date: July 16, 2000
Last Revision Date: November 21, 2014
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure access and coordination of services when a member or provider is requesting a second opinion evaluation.

POLICY:

Members, providers, and the Medical Director/Physician Reviewers have the right to request a Second Medical Opinion by an Appropriately Qualified Health Care Professional whenever any of the following occurs:

- If there is question of the reasonableness or necessity of recommended surgical procedures.
- If there is question of 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.
- If the 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.
- If the treatment plan in progress is not improving the medical condition of the member 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.
- If the member has attempted to follow the treatment plan or consulted with their Primary Care Provider regarding serious concerns about the diagnosis or plan of care.

If a member is seeking a second opinion from the findings of their primary care physician, the member will be referred to a provider within the IPA's network within the appropriate **timeframe** to the type of request (i.e., urgent, non-urgent, concurrent, post-service).

If the member or their primary care provider is requesting a second opinion as a result of a first opinion by an in-network specialist, the member may be referred to a specialist who is outside the IPA's network but is a health plan network provider. In this case, the UM Coordinator will assist the member in contacting their health plan and coordination of the referral process. The out of network second opinion may be the health plan's

financial responsibility. For members with commercial coverage requesting a second opinion by a non-contracted provider, the request will not be denied but will be coordinated with the member's health plan. The member's ability to travel to the location of the second opinion provider's office will be taken into consideration before authorization of service to that provider.

The member shall be responsible only for the costs of applicable co-payments that the plan requires for similar referrals and at no cost to Medi-Cal members.

The primary care physician, when necessary, will ensure that medical records, in accordance with release of medical information policies, related to the member's condition requiring second opinion are forwarded to the second opinion specialist for review. Depending on the nature of the member's condition the member may need to check out film x-rays and bring with them to the second opinion consultation.

The physician providing a second opinion consultation is required to provide both the member and the primary care provider with a consultation report, including recommendations for tests or procedures.

If the second opinion findings result in the denial of the initial request for service, the member will be notified in writing and will be notified of their right to file a grievance or appeal.

After the second opinion is obtained, the member will return to the initial specialist or primary care physician for treatment plan. If the first opinion and the second opinion greatly disagree the member may be referred for an additional and final opinion. In this case if the second opinion was a provider within the IPA's network, the primary care physician should refer to a health plan network specialist.

Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.

DEFINITION:

Appropriately Qualified Health Care Professional: A primary care physician, specialist or other licensed health care provider who is acting within his or her scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition, or conditions associated with the request for second opinion.

PROCEDURE:

1. Members will be referred for second opinion to Appropriate Qualified Health Care Professionals (primary care physicians or specialists) whose scope of practice and clinical background includes

training and expertise related to the member's illness, disease condition or conditions associated with the request for second opinion.

2. Providers will refer all members for second opinions through the "Referral Authorization" process. The second opinion decision will be rendered in an expeditious manner appropriate to the member's condition, not to exceed 72 hours after the receipt of the request.

3. The UM Coordinator will ensure that the second opinion provider is contracted with the medical group or member's health plan. The UM Coordinator will assist the Primary Care Physician in locating a second opinion provider within the health plan network when necessary. [For Blue Cross Commercial, the member will be instructed to contact Blue Cross Customer Service number on the back of their ID card.]

4. The health plan's Utilization Management Department will be notified of all requests for Second Opinion. Some health plans may require a TAR be sent for their review in addition to the IPA's review.

FORMS:
Referral Authorization Worksheet

REFERENCES:
AB 12: Second Opinion (1/2000) Amended by AB 2903 (1/2001)
NCQA UM3

SUBJECT: Continuity of Care (CoC) **Policy #:** UM19
DEPARTMENT: Utilization Management

Effective Date: July 1, 2000
Last Revision Date: June 19th 2025
Last Review: June 2026

SCOPE:

This policy applies to all lines of business.

For Health Plans that do not delegate Continuity of Care Services, the health plan required process will be followed immediately upon receipt of request for COC. This may include but is not limited to same day submission of any health plan required form and/or telephonic contact with the required health plan representative.

PURPOSE:

To ensure coordination and direction of care prior to member exhausting their benefit. This includes but is not limited to coordination when a member transitions from pediatric care to adult care.

To ensure access and coordination of services when member is currently receiving an active course of treatment by contracted or non-contracted specialty provider or when specialty provider currently seeing member has terminated his/her contract with the medical group.

This policy is meant to ensure continuity of care for members in an active course of treatment under the following circumstances:

- Member is receiving treatment for an acute episode of chronic illness or acute medical conditions; or
- Member is in the 2nd OR 3rd Trimester of Pregnancy and currently under the care of an OB Provider. This would include and is not limited to members receiving maternal mental health services according to the required timeframes.

POLICY:

Provider Services will notify the UM Department and the Health Plan(s) of all contracted physicians who gave a 90-day notice of termination of participation, 60 days prior to the termination date. When provider services is not provided with timely notice of termination of participation, the health plan will be notified immediately or within 15 calendar days. At that time the UM Department will review the activity with that provider to ensure continuity of care. Members will be notified **60** days prior to the termination effective date. UM staff will ensure that members are either transitioned to providers within the network or provider services implements one-time contracts for non-contracted providers.

When a provider cancels his contract with the medical group, he must give notice according to his contract and continue to see members through his contract termination date. If the patient's care needs exceed the expiration date of the provider's contract with the medical group, the Contract Manager will negotiate a one-time contract for the member to continue care.

When a provider does not provide the IPA with 90-day notice of termination, the provider services department will notify the UM department upon receipt of the notification from the provider. Members will be notified by Specialist Term letter at least 60 days prior to termination or as soon as possible if the provider did not provide the IPA with at least 90 days notice of termination.

For plans that do not delegate, or where partial delegation exists, the group will follow the plans required coordination process and refer the member to the health plan as applicable. For example, Cigna delegates review and approval of COC but if COC cannot be approved, it must be sent to Cigna for review and denial of COC.

When member transfers into the IPA and is currently under the care of specialist who is contracted with the group, the PCP will submit a referral for the member to continue services with that provider.

If the provider is not contracted with the medical group and the member's condition is in a chronic phase, but not in any risk for changing to a contracted provider, the member will be referred to a contracted provider.

If the member is in an acute phase in which a break in continuity of care could cause potential harm to member's treatment plan, all attempts will be made to ensure that no break in care occurs. This may include the contract manager negotiating a one-time contract for the member to continue care with the non-contracted provider.

If the member is admitted and while inpatient disenrolls the IPA will continue to cover, through discharge, inpatient services if the member was assigned at the beginning of the inpatient stay.

All attempts will be made to maintain continuity of care for members who are currently undergoing an active course of treatment with a specialist in and out of network, including behavioral health. As mandated by SB59, following a concurrent review, care shall not be discontinued until the treating provider has been notified and agrees to a care plan.

The group is not required to provide continuity of care to a provider terminated for reasons related to medical disciplinary cause.

The group must ensure continuity of care for Medi-Cal beneficiaries who transition from fee-for-service (FFS) Medi-Cal into Medi-Cal managed care and including those members which have requested a Medical Exemption Request [MER]. The health plan will notify the group of members requesting a MER and the group shall ensure continuity of care through determination of MER status.

Per NCQA, continuation of treatment shall be through the lesser of the current period of active treatment, or for up to 90 calendar days for members undergoing active treatment for a chronic or acute medical condition.

The Member Services Department will supply the Case Management Department with a list of members who are nearing an age limit of continuing care with an assigned Pediatrician. The Pediatrician in coordination with a Case Manager will also assist pregnant adolescents in their transition from pediatrics to an adult primary care practitioner, OB/GYN, family practitioner or internist. This may occur by notification to individuals and/or their caretakers of the need for care to be provided by an adult provider along with instructions on how to contact their health plan or warm transfer call to ensure timely transitions. The Case Manager may follow up with the member after the transition to identify any additional needs.

<u>Medi-Cal Seniors and Persons with Disability</u>:

SPD members are identified by Data supplied from health plan or from review of applicable Aid Codes according to eligibility list. When requested by the member, the group will provide continued access for up to 12 months for SPD members requesting continuity of care (COC) with a non-contracted provider that the member has an ongoing relationship with, if the Provider is willing to accept a one-time contract at a rate no more than the prevailing Medi-Cal rate.

For LIHP/Healthy Ways/OTLIC/Covered California Behavioral Health Treatment for children diagnosed with Autism Spectrum Disorder transitioning from Regional Center Care/Medi-Cal Expansion & Dual Eligible:
The group will provide continued access for up to 12 months for members requesting continuity of care (COC) with a non-contracted provider when the member has an established ongoing relationship the provider, as long as the Provider is willing to accept a one-time contract. If the provider refuses to contract, the member will be offered an in-network provider option.

- For CalOptima, the provider will be offered a minimum of the CalOptima Medi-Cal rate but there is no required maximum rate for one-time contract as in place for SPD. Consideration for reasonable and customary consideration should be given prior to any denial of service.

Health Homes Program – Medi-Cal Fee for Service [FFS] transition to Managed Care**:**
The group must provide continuity of care with an out-of-network provider for Medi-Cal FFS beneficiaries who voluntarily transition to a managed care plan to enroll in the Health Homes Program. Because Home Health Program Services are provided only through the managed care delivery system, continuity of care with out-of-network-providers would not apply to those services. However, if a member has additional service needs and CoC is established, coverage will follow this policy.

The Medical Group will maintain continuity of care for medical behavioral health and long- term services and support upon new enrollment according to guideline dictated by the plan. The group will allow members to maintain their current providers for up to six months for primary and specialty services and for up to 12 months for Medi-Cal services if all the criteria is met:

1. The member demonstrates an existing relationship with the Provider prior to enrollment. An existing relationship means a member has seen an out-of- network primary care provider at least once or a specialty care provider at least twice during the 12 months prior to the date of his or her initial enrollment for a non-emergency visit. This may be established by using Medi-Cal Fee for Service claims or encounters, Authorization data or history that is documented and verified with the provider.

2. The Provider is willing to accept payment on the current Medicare fee schedule; and

3. The group's verification of the Provider would not otherwise exclude the provider.

For Members Transitioning to a Medicare Advantage Plan:

The group will provide a minimum 90-day transition period when a member is currently undergoing treatment and will not require prior authorization for the active course of treatment. Prior authorizations will be valid for as long as medically necessary based on the members medical history and the treating provider's recommendation to avoid disruptions in care.

For Covered California to Medi-Cal Transition:
A good faith effort will be made to ensure members who transition from Covered California to Medi-Cal managed care to assess members active treatment status, preferably within 15 days of enrollment. Active treatment coordination of care will be coordinated for a minimum of 60 days or until a new assessment is completed by the PCP. The prior treatment will be honored without a request by the PCP or member. At the member or PCP's request, continuity of care for out of network providers will be offered for up to 12 months.

For the Whole Child Model [WCM] Program:
All Medi-Cal continuity of care requirements apply in addition to the following:

1. Continued access to current CCS Providers for services that were authorized prior to transition to WCM, regardless of network affiliation, for up to 12 months.

2. Continued access to Case Management and Care Coordination with their existing Public Health Nurse [PHN] when requested within 90 days of the transition to WMC, for up to 12 months. If the PHN is unavailable, the member will be assigned a Case Manager who has adequate training and clinical expertise with the CCS population or pediatric complex medical conditions.

3. Continued access to specialized or customized durable medical equipment (DME) for 12 months for those with an established relationship and extension beyond 12 months for specialized or customized DME still under warranty and deemed medically necessary by the treating provider.

4. Continued access for already approved Inter-County Transfer service authorization requests for the members moving into/out of the county.

5. Continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition until CalOptima and prescribing provider agree it's no longer medically necessary or the medication is no longer prescribed by the CCS program provider.

WCM members or their designated representative can appeal any limitations regarding continuity of care request. The member will receive a notice with the detailed process for their appeal, including rights for State Fair Hearing. CalOptima is responsible for all appeal processing. If the group receives a verbal request to appeal, it will be forwarded to CalOptima.

Pediatric Palliative Care [PPC] Waiver - Medi-Cal Fee for Service [FFS] transition to Managed Care**:**
For members who were previously covered under the Pediatric Palliative Care Waiver Program, members, the provider or a Member's representative may request continuity of care for out of network providers who provided Medi-Cal-covered PPC waiver services to the members that are also covered under EPSDT for up to 12 months.

Continuity of care is considered complete when the member is informed of their right to continued access and coordination of care is performed, rates for payment have been agreed to, no quality concerns are identified, and Letter of Agreement (LOA) is complete. If the Provider is non-responsive in the process, the group must allow 30 calendar days for good faith effort before transferring care to another Provider, unless the member's health is at risk. Members will be notified 30 days prior to the expiration of the LOA, for coordination of care transitioning to network providers.

Continuity of care request must be completed within:

1. 30 calendar days from the date the request is received.

2. 15 calendar days if the medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs*:* or,
3. 3 calendar days if there is risk of harm waiting the standard timeframe.

A member changes groups, the CoC period may start over one time. If the member changes a second time (or more), the CoC period does not start over and does not have the right to a new six or 12-month period. If the member returns to fee-for-service (FFS) Medi-Cal the CoC period does not start over. If a member changes MMP, CoC does not extend to out-of- network providers that the member accessed through their previous MMP.

The group is not required to provide provider continuity of care with an out-of-network provider if any of the following circumstances exist:

1. When services are not covered by Medi-Cal or Medicare.

2. Services are medical equipment (DME), transportation, other ancillary services, or carved-out services (however, continuity of services is required).

3. The provider does not agree to abide by the utilization management policies.

In some cases, in order to maintain continuity of care, without interruption with the referral process, a case may be given a long-term authorization, and the case will be referred to Case Management. The provider is responsible for verifying eligibility on a monthly basis and give updated treatment plans to the Case Manager. Extensions for authorization of care will be presented to the Medical Director along with the treatment plan for final determination of extension.

At the time a member has been authorized for services which have limited benefit coverage or expiration date, the case will be referred to Case Management to ensure that a treatment plan is in place prior to the member exhausting their benefit.

DEFINITION:

Active Course of Treatment One in which a break in continuity of care could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcome.

Acute Condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem which requires prompt medical attention, and which has a limited duration. Continuity of Care (COC) is provided for the duration of the acute condition but shall not exceed twelve (12) months from the contract termination date.

Chronic Condition: A medical condition, usually of slow progress and long continuance, and other than a Serious Chronic Condition, requiring ongoing care. COC is provided for the duration of the chronic condition but shall not exceed ninety (90) days from the contract termination date.

Serious Chronic Condition: A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Continuation of care is provided for

the duration of the chronic condition but shall not exceed twelve (12) months from the contract termination date.

Pregnancy: Continuation of care through the three trimesters of pregnancy and the immediate postpartum period.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing death within one year or more. Completion of covered services shall be provided for the duration of the terminal illness.

Care of a Newborn Child: between birth and the age of 36 months. Continuation of care is provided for the duration of the chronic condition but shall not exceed twelve (12) months from the contract termination date.

Performance of Surgery or Other Procedure: that is authorized by the plan as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 calendar days of the contract's termination date.

Mental Health Acute Condition: A mental health condition that involves a sudden onset of symptoms that requires prompt mental health attention and that has limited duration. Transition period of 90 days or through the acute period of illness, whichever is shorter, to continue course of treatment with the nonparticipating mental health specialist.

Mental Health Serious Chronic Condition: A mental health condition that is serious in nature and requires ongoing treatment to maintain remission or prevent deterioration. Transition period of 90 days or through the acute period of illness, whichever is shorter, to continue course of treatment with the nonparticipating mental health specialist.

PROCEDURE:

A. All cases in which a member is authorized for services with a specific number of visits or treatments as explained by the members plan coverage will be referred for Case Management intervention.

B. New members to the medical group currently under care with a contracted provider will be re-referred to that same contracted provider through the referral process.

C. In some cases, in order to maintain continuity of care, an extended referral authorization may be granted, (ie. Radiation and/or chemotherapy treatment. A treatment plan will be reviewed to ensure need for Case Management intervention).

D. When a member is new to the group and currently under treatment with a non-contracted provider and in an acute phase where break in continuity could cause harm to member, a one-time contract will be made through the contracting department to ensure no break in member's care. Providers and members will receive written notification that they have received out of network care that would not be covered at in network level.

E. When a provider cancels his contract with the medical group,

1. The Credentialing and/or Provider Services Department will notify the UM Department.
2. The UM Department will review all members who may currently be under the care of the provider.

3. A current treatment plan will be requested for each member.
4. Those members where no harm would occur for transfer to another provider will be contacted with new provider name, address, phone number and authorization number.
5. For those members currently under treatment, in which a break in continuity would cause harm to the member, the Contract Manger will coordinate a one-time contract with the provider for the duration of member's care.
6. Effective July 2003, Specialists are also responsible for notifying the member of a contract termination with the member's IPA.
7. The UM department will

F. When a member's benefits have been exhausted, the PCP and/or Case Manager will discuss with the member alternatives for care. Notice of Action letters will be completed. Direction will be member specific but is not limited to referrals to community-based services, educational programs, teaching for self-care, etc.

G. Education to Providers regarding CoC is done annually.

H. Processing Continuity of Care Requests

1. A request may be made verbally or in writing by a member, member's representative or provider.

2. Retroactive request must have occurred after the enrollment date and must have the ability to demonstrate that there was an existing relationship between the member and provider prior to enrollment. Approved retroactive requests shall meet the following requirements:

   A. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement.

   B. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is requested.

3. A request for CoC will begin within five working days after receipt of the request and the request must be completed in three (3) days if there is a risk of harm to the member.
4. Verification of the pre-existing relationship is required; therefore, provider documentation is required.

5. After validating the pre-existing relationship, contact the provider and make a good faith effort to enter into a contract or letter of agreement to establish a CoC relationship for the member.

6. The member will have access to that provider for the length of the CoC period unless the provider is only willing to agree for a shorter timeframe. In this case, the member will have access to that provider for the shorter period of time.

7. If an agreement cannot be reached with the provider or a documented quality of care issue is noted, the member may select from the contracted in-network providers.

8. If the member does not make a choice, an in-network provider will be assigned, and the Member will be informed of their right to file an appeal through the Medicare and Medi-Cal processes.

9. At any time, the member may change their provider regardless of whether or not a CoC relationship has been established. When the CoC agreement has been established, the group will work with the provider to establish a care plan.

10. Members will be notified of the Approval within seven calendar days. The notification will include:

    - Notice that member is receiving services.
    - The request approval.
    - The duration of the CoC arrangement.
    - The process for transitioning back to in-network at the end of the CoC period; and
    - The right to choose a different provider from the plan's provider network.

11. The member will be notified 30 calendar days before the end of the CoC period to engage the member and provider in the transition process and selecting an in-network provider.
    a) For members enrolled in the Whole Child Program, the member will be notified 60 calendar days before the end of the CoC period. The CalOptima CoC notice will include an explanation of the member's right to petition for an extension of CoC period, criteria used to evaluate the petition, and appeals process if petition is denied.

12. Members residing in a Nursing Facility prior to enrollment will not be required to change NFs if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards and the facility and group agree to Medi-Cal rates in accordance with the three-way contract. This provision is automatic, meaning the member does not have to make a request for CoC. Duration of residency through the same process specified previously for verifying a pre- existing provider relationship, which is through historical utilization data or documentation from the member or provider.

13. Reporting will be submitting timely to the health plans on the required template monthly or quarterly as required by the plan.

FORMS:
None required.

REFERENCES:
SB 1129 Continuing Coverage of Services by Terminated Provider
APL 22-032

SUBJECT: Mental Health/Behavioral Health Triage &Coordination of Service **Policy #:** UM18

DEPARTMENT: Utilization Management

Effective Date: July 1, 2000
Last Revision Date: March 20, 2023
Last Review: January 202**6**

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure access and coordination of services between Primary Care and Mental Health/Behavioral Health programs and providers.

POLICY:

The IPA covers outpatient mental health services that are within the scope of Primary Care Physicians. If the PCP determine or suspects that a member is Serious and Persistently Mentally Ill (SPMI) and in need of outpatient Specialty Mental Health Services, beyond the PCP's scope of practice, the member will be referred to the appropriate provider according to their health plan.

For members identified with Alcohol misuse, the PCP will perform a Screening, Brief Intervention and Referral for Treatment. Each PCP will designate an individual(s) in the office to assist with this screening. A four-hour course is required for certification on this process and certification must occur within 12 months from onset of program. Referrals for further intervention and treatment programs will be coordinated with the member's health plan Case Management.

Mental Health/Behavioral Health screening, examination, evaluation and treatment shall be conducted by a medical professional that is trained in psychiatric medicine or, other personnel to the extent permitted by the applicable law and within the scope of their licensure and privileges. Per AB 213 this also includes Licensed Marriage and Family Therapist.

The IPA is required to ensure the provisions of all services related to Primary Care and coordinate medical services when a member is under the care of a Mental Health Provider. This includes but is not limited to coordinating and providing medically necessary services for members who are diagnosed with feeding and eating disorders and are currently receiving Specialty Mental Health Services (SMHS) from a county Mental Health Provider.

Strict confidentiality will be maintained regarding all cases in accordance with Federal and State law. Only with a release of information (Coordination of Care Form) signed by the member, will the behavioral health provider release vital patient information to the member's Primary Care Physician. This vital information includes:

- Member's Name
- Medication, name & dosage prescribed
- Mental Health/Behavioral Health Provider's name, credentials address & Phone number
- Summation of first assessment, DSMIV Diagnosis and essential elements of the treatment plan

All pertinent communication from the Mental Health/Behavioral Health provider will be documented in the member's file.
The Mental Health/Behavioral Health provider shall then provide written communication to the Primary Care Physician at the 10th visits and the 20th visits (where benefit applies) and when there are changes in level of care. The provider may also contact the Primary Care Physician when clinically appropriate such as in cases of:

- Concern for the member's physical safety or the safety of others interacting with the patient
- Indication that the member may be abusing prescription medications or illegal drugs
- Presentation of symptoms that may be medical in origin
- Indications of adverse reaction(s) to medication

All Mental Health/Behavioral Health referrals for service will be logged and may also in some cases be referred to Case Management to ensure coordination of care.

For members who are diagnosed with feeding and eating disorders, where delegated, the IPA is responsible for providing Comprehensive Medical Case Management Services, including coordination of care, to ensure provision of all medically necessary services, whether those services are delivered within or outside of the IPA's provider network. These services are provided through either basic case, complex case or Enhanced Care Management activities based on the medical needs of the member. Where not delegated, the Case Manager will coordinate with the member's health plan for these services.

Depending upon the contract language, Mental Health/Behavioral Health services may be considered a "Carve Out" program. Each plan contract and benefit matrix will be reviewed for determination.

- For example, Well Care members may self-refer for Mental Health.
- Mental Health services are available for self- referral 24 hours a day 7 days a week even though services are a carve out and covered by L.A. Care.

When a member presents at an Emergency Room with a possible psychiatric emergency, a psychiatrist or triage team will provide a medical screening exam and communicate a treatment plan. When admissions occur, the Concurrent Review Nurse/Case Manager will ensure that the Primary Care Physician is notified of the case through the usual Concurrent Review Process.

Contractually, the medical group is usually responsible to ensure that a medical history and physical occurs for all psychiatric admissions.

DEFINITIONS:
None required

PROCEDURE:

A. Requests for Mental Health/Behavioral Health triage will be requested through the usual referral process. (See policy UM 4: Referral Authorization Process).

B. Determination will be made regarding benefit coverage and whether or not the benefit is a "Carve Out" program or to be administered by contracted psychiatric providers with the group.

C. Clinical triage will be performed by Behavioral Health Care Practitioners with appropriate qualified experience. Determination for urgency and level of care will be determined. Current and appropriate written mental health and substance abuse protocols will be followed.

D. The Medical Director will authorize initial referrals for clinical triage and evaluation of Mental Health/Behavioral health needs to a contracted provider. The Medical Director may contact a psychiatrist, doctor level clinical psychologist and or certified addiction medicine specialist to assist in determination of level of care and criteria for coverage.

E. When the member's coverage is considered a "Carve Out" program service, such as mental health:

1. The UM Coordinator will ensure that the Primary Care Physician directs the member to the plan contracted program. Depending upon the program provided by the plan, this may be accomplished by use of the 800 number for access to the program or a call to the health plan to obtain authorization to contracted provider.

2. In the case coordination for members with Medi-Cal coverage, the member will be referred to Medi-Cal Fee for Service mental health provider or to the local mental health delegate for specialty mental health services in accordance with the requirements for specialty mental health services. The IPA will also coordinate with each health plan or its designated delegate/vendor for **outpatient** mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning when their needs fall outside the PCP's scope of practice. For members with **severe** mental health impairment, Medi-Cal Specialty Mental Services will continue to be provided by the county.

3. Mental Health County providers for evaluation and treatment plan.

4. The case will be referred to the Case Management Department for coordination of care. The case manager will work with the PCP to assure that all referrals are appropriately reviewed and completed; the member and his/her family is aware of the proposed treatment plan; and there is appropriate coordination between all health care inter-agencies (See Case Management Program, Section V)

5. When the member's coverage is considered the IPA's responsibility, the member will be referred for triage to a contracted provider, through the referral process. The provider will make a recommendation for treatment and the member will be referred to the Case Management Department for follow-up (See Case Management Program, Section V).

F. The Primary Care Physician will be responsible to ensure that the member signs a "Coordination of Care Form".

G. Once a Coordination of Care form is signed, the Primary Care Physician is responsible to maintain a copy in the member's file and document all coordination with the Mental Health/Behavioral Health providers.

H. Any requests resulting in denial of mental health/Behavioral health services must be reviewed by a medical professional that is trained in psychiatric medicine, unless the denial is due to member's eligibility and benefit with their health plan.

I. For any inpatient care, intensive outpatient and residential Behavioral health cases, all concurrent review decisions will be made within one working day of obtaining all necessary information.

J. A log of all Mental Health referrals will be maintained and reported to the health plan on a monthly basis.

FORMS:
Coordination of Care Form – Behavioral Health Specialist/PCP

REFERENCES:

Not applicable

SUBJECT: Abnormal Study Follow up **Policy #:** UM17
DEPARTMENT: Utilization Management/Office P & Ps

Effective Date: June 6, 1997
Last Revision Date: February 2007
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To provide guidelines for recalling members in a timely manner when abnormal findings or report occurs.

POLICY:

The Primary Care Physician is expected to review all clinical results and prioritize appropriate timely follow-up for abnormal diagnostic findings or imaging services.

DEFINITIONS:

None required.

PROCEDURE:

A. PRIMARY CARE PHYSICIAN responsibility:

1. All clinical reports are reviewed daily and signed/initialed by the ordering physician.

2. If the results are abnormal, the PCP prioritizes the urgency of patient contact or recall effort.

3. If the record has a "ANORMAL" stamp, complete the required instructions on the stamp and indicate if the patient is (1) to return to the clinic: (2) repeat study/test or (3) no action required (indicate reason). If the stamp is not available, document the same information on the medical record.

4. Initiate or delegate to medical office staff the member contact as prioritized.

B. MEDICAL OFFICE STAFF responsibilities:

1. Maintain a clinical study log. At a minimum the information should include:

a. Patient Name

b. File number

c. Test(s) ordered

d. Date Ordered

e. Date results received

f. Indicator for abnormal

2. Follow up to ensure results are received and available for review by the physician. All specialty services, consultations or procedures shall be filed in the chart within two weeks unless required sooner.

3. If the results are determined to be abnormal, use the "ABNORMAL" stamp in the member's medical record or on the report itself. Do not obstruct documentation in the record or in the report.

4. Only physicians are allowed to directly give abnormal test results to patients.

5. Assist the physician in member recall efforts that may include the need for appointment, repeat or additional tests.

6. Recalls require a minimum of three attempts (phone or letter):

    a. First Contact – attempt telephone contacts the same day as physician receives results. Send a letter to the patient if no phone contact is available.

    b. Second Contact – Call within two days results are reviewed. Send a second letter within one week if no phone contact is available.

    c. Third Contact – send letter to patient.

7. Document all recall efforts in the medical record.

8. File all clinical results, reviewed and initialed by the physician, in the medical record along with copies of any correspondence sent to the member.

C. UM COOORDINATOR/CASE MANAGER responsibilities:

1. All medical records, test results received at the IPA must be forwarded to the member's Primary Care Physician for review and recommendation for follow up.

2. Specialty physicians requesting follow up care due to ABNORMAL findings upon their exams or studies will be referred back to the member's Primary Care Physician.

3. The Case Managers, UM Coordinators and other employees will maintain confidentiality on any abnormal findings received.

4. The UM Coordinators will not forward copies of ABNORMAL findings with request for a referral to a specialist to the medical director unless the request came from the primary care physician and the record has been initialed by the member's Primary Care Physician.

FORMS:

Not applicable

REFERENCES:

None required.

SUBJECT: Under and Over Utilization of Services **Policy #:** UM16
DEPARTMENT: Utilization Management

Effective Date: October 7, 1999
Last Revision Date: February 2016
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure that care is monitored, analyzed and interventions are implemented when under and over utilization patterns are identified.

POLICY:

All practitioners and providers throughout the IPA will be responsible to comply with policies regarding use of appropriate service and UM guidelines.

The UM Department will review a variety of utilization resources to monitor for under and over utilization. Data gathered will be analyzed to identify causes and corrective actions will be implemented to correct any instances of potential or actual under or over utilization.

DEFINITIONS:
None required.

PROCEDURE:

A. The UM/QM Committee will review all monthly reports to monitor over and under utilization patterns according to standards set by committee.

B. The UM/QM Committee will take responsibility for the timely intervention of practice wide, product line and practice specific problems.

C. Committee findings and activity planned will be noted in the minutes of the meeting.

D. Areas of Measurement are as follows:

1. Denial Rates:
2. Case Management services (ie. CCS, Catastrophic case management criteria)
3. Preventative Health (IHA, Immunizations)
4. Ancillary Services (Home Health)
5. Emergency Room (ER/1000)
6. Out of Area/Network treatment (provider or practice specific)
7. Specialty services (referrals to Behavioral Health, Ophthalmology, Orthopedics)

8. Facility services (Bed Days/1000, Length of stay)
9. Level of Care (SNF Days)
10. Inter-rater Reliability scores
11. Appeal overturn rates
12. Will take into consideration other QI Monitoring activities reported to the UM Committee such as Grievances & Potential Provider Quality Issues.

E. Through review, the UM Committee will ensure that UM decision making is based upon medical appropriateness.

   1. The IPA will not compensate or offer incentives for denial of services.
   2. The committee will identify thresholds for under and over utilization and will recommend appropriate interventions as needed.

F. Special concerns regarding under utilization of services will be distributed to the providers, practitioner, and staff.

G. Members, who are identified with specific individual concerns, such as over utilization of emergency room services, will receive health education correspondence.

H. The areas of measurement will be revised and updated as needed (changes in local delivery system, practice mix, etc.) Once revisions are implemented, re-measurement, at a time sufficient to allow improvements to take place, will be performed.

FORMS:

None

REFERENCES:

Not applicable

SUBJECT: Preventive Health Services **Policy #:** PH1
DEPARTMENT: Utilization & Quality Management

Effective Date: January 1, 1999
Last Revision Date: March 2, 2023
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define the guidelines for the provision of preventive services and standards of care that meet community standards.

POLICY:

IPA providers are responsible for providing periodic health screening for Pediatric, Adult and Obstetric Preventive Care, and for providing care according to standard guidelines established on a scientific basis by providers who have knowledge and involvement in the adoption and/or development of the guidelines, and/or by state and federal agencies.

The guidelines which providers are responsible to follow include, but are not limited to:

1) Periodic health screening schedules for Pediatric Preventive Care based upon the most recent recommendations of the American Academy of Pediatrics (AAP) and the Child Health and Disability Program services (CHDP).

2) Standards for adult preventive care based upon the guidelines contained in the most recent guide to clinical Preventive Services of the US Preventive Task Force and Advisory Committee on Immunization Practices (ACIP).

3) Standards for Obstetric preventive care based upon he most recent recommendations of the American College of Obstetrics and Gynecology (ACOG).

4) Standards and care for the treatment of tuberculosis that are based on the most recent guidelines recommended by the American Thoracic Society and the Center for Disease Control.

Other documented guidelines in use by the providers shall show evidence of being developed and/or approved by the area documented.

Prior authorization is not required for preventive services.

DEFINITION:

CHDP: The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low-income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic

and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts.

PROCEDURE:

A. Primary Care Physician (PCP) responsibilities:

1. The PCP is responsible for scheduling initial and periodic care visits according to the guidelines set forth in this policy, including but not limited to:

    a. Periodic health screening schedules for Pediatric Preventive Care based upon the most recent recommendations of the American Academy of Pediatrics (AAP) (covers age birth to 21 years) and the Child Health and Disability Program services (CHDP).

        1) CHDP services begin within the 120 days of enrollment in a managed care plan. (See P&P UM26 Initial Health Appointments).
        2) PCP is responsible for initial notification and all follow-up notifications to ensure that CHDP guidelines are met.

    b. For Children: The CDC and AAP recommend screening for developmental delay and disability during well care visits at age 9, 18, 24 and 30 months.
        i. This includes Autism Spectrum Disorder specific screenings at age 18 months and 24 months. This may be accomplished by using the M-CHAT and M-CHAT-R screening tools.

    c. Standards for adult preventive care bases upon the guidelines contained in the most recent guide to Clinical Preventive Services of the US Preventive Task Force (covers ages 21 - >75)

    d. Standards for immunizations based upon the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP). ACIP-recommended immunizations are viewed as preventive services, these services must not be subject to prior authorization.

    e. Standards for Obstetric preventive care based upon the most recent recommendations of the American College of Obstetrics and Gynecology (ACOG).

    f. Standards and care for the treatment of tuberculosis that are based on the most recent guidelines recommended by the American Thoracic Society and the Center for Disease Control.

2. The PCP is responsible for complying with the Medical Records Guidelines and Continuity of Care Guidelines as set forth in the policies for documentation, evaluation, and follow-up standards. Policies include:

    MR1 Medical Records Standard Review
    MR2 Medical Records Screening Criteria
    MR3 Medical Record File Maintenance
    UM19 Continuity of Care

3. The PCP coordinates the scheduling and periodic care visits of an initial health assessment and ongoing and annual wellness assessments as required by age and periodicity. All good faith efforts to annually notify enrollees about the Annual Wellness Visit will be documented.

4. The PCP is responsible for ensuring members are informed of specific health care needs that require follow up and receive, as appropriate, information to support and promote their own health. Barriers to care will be discussed and documented and may include referral to Case Management to assist the members in ensuring their compliance with treatments planned. Timely coordination of referral to Case Management and/or additional referral for service needs will be documented.

B. IPA Responsibilities:

1. Every two years, all preventive guidelines will be reviewed and approved by the QI Committee.

2. The QI Committee will reflect the adoption and/or update of the specific guidelines.

3. Newly adopted and/or updated guidelines will be disseminated to all providers.

4. Documentation of member's need for ACIP-recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters:
   - Illness, care management, or follow-up appointments
   - Initial Health Appointments (IHAs)
   - Pharmacy services
   - Prenatal and postpartum care
   - Pre-travel visits
   - Sports, school, or work physicals
   - Visits to an LHD
   - Ongoing and Annual Well patient checkups

C. Compliance Monitoring:

1. The Quality Improvement activities related to compliance monitoring include but are not limited to:

   a) Medical Records Audits (High Risk, counseling, anticipatory guidance)

   b) Initial Health Assessment Audit.

   c) CHDP Program Audits (Periodic screening guidelines)

   d) Facility Site Audits (Availability of services, access, medical equipment and supplies, vaccines)

2. Non-compliance with this aspect of the QI Program will result in corrective action plan and be reported to the QI Committee if disciplinary action is warranted.

FORMS:
Staying Healthy Assessment
SBIRT

ASD-specific screening form: M-CHAT and M-CHAR-R. These forms are available at Bright Futures: https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx.

REFERENCES:

See Policies and Procedures:

MR1 Medical Records Standard Review
MR2 Medical Records Screening Criteria
MR3 Medical Record File Maintenance
UM19 Continuity of Care

American Academy of Pediatrics
Clinical Preventive Services of the US Preventive Task Force
American College if Obstetrics and Gynecology (ACOG)
American Thoracic Society
The Center for Disease Control
Periodicity Tables
APL 18-004

SUBJECT: Inter-rater Reliability **Policy #:** UM13
DEPARTMENT: Utilization Management

Effective Date: May 28, 1997
Last Revision Date: June 9th 2025
Last Review: June 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To provide on going assessment of all licensed and non-licensed staff involved in the UM review process for the following:

- Measurement of consistent use of the medical review criteria, benefit interpretation and data entry activities.
- Establishment of consistent reporting and feedback mechanism.
- Assistance in the development of standards and/or policies and procedure revisions.
- Determination of the overall effectiveness of the UM Program.
- Identification of area for quality improvement performance by an individual or the UM department.

POLICY:

All licensed staff, non-licensed staff, and physicians involved in the UM review process will be assessed during the probationary period and annually thereafter.

Designated auditor who has same degree of expertise will assess licensed staff (i.e., nurse will review nurse; physician will review physician, etc.)

A measurement tool will be utilized in the review. Information measured may contain, but is not limited to the following:

Licensed Staff

- Verification of eligibility, benefits, provider contract status
- Clinical documentation reflects requesting and referring to provider, type of service (routine, urgent, emergent), authorization number, CPT & ICD-10 codes, level of care, number of visits or length of stay, medical necessity and appropriateness, shared risk approval by health plan.
- Timeliness of authorization activities, stamped dates of activity
- Outcome including timeliness and appropriate letter usage. For denials, documentation of rationale.
- Appropriate referral identified for Direct Access, CCS, Case Management, Quality Management and one-time referral needs.

Non-licensed Staff

- Verification of eligibility, benefits, provider contract status
- Clinical documentation reflects requesting and referring to provider, type of service (routine, urgent, emergent), authorization number, CPT & ICD-10 codes, shared risk approval by health plan.
- Timeliness of authorization activities, stamped dates of activity
- Outcome including timeliness and appropriate letter usage.

Physicians

- Appropriate use of specialty services
- Appropriate referral decision
- Documentation and signature
- Timely review of referral
- Documentation regarding pending of referral, if required
- Documentation of clinical criteria/reason for modifications and denials
- Listing of alternate plan of care, where indicated.
- Recommendation for referral to community resources, where appropriate

A random sampling of files will be reviewed. Non-licensed staff will be reviewed separately from licensed staff. Staff who perform a combination of inpatient and outpatient referral activity will be reviewed on an equal percentage of both as determined by the overall caseload within each area.

Physician review will be performed by the UM physicians participating in any decision-making utilizing de-identified records for individual case review.

Compliance standards:

- Full Compliance: 95-100% overall score
- Partial Compliance: 80 – 95% overall score
- Non-Compliance – less than 80%

A report of findings will be scored and reviewed with each staff member to discuss compliance and any areas requiring improvement. The Medical Director will review scores with the physicians.

In the event that the results are less than 95%, a corrective action plan will be developed, training and follow-up testing will occur within 7 days for employees who do not meet 95% compliance threshold.

Any employee not meeting the 95% standard will not conduct reviews without direct supervision until full compliance is achieved. New employees may be extended on probationary status, if necessary.

Composite scores will be made available to the health plans for review. No data will be shared which details the individual or reviewer identification.

DEFINITIONS

None required.

PROCEDURE:

A. All UM Staff and UM physicians will be reviewed one time per year, minimum, as designated in the UM Work Plan. (New employees will be reviewed during their probationary period and after meeting compliance will be reviewed one time a year thereafter along with the other staff).

B. The 8/30 methodology will be utilized by making a random de-identified sampling of 30 prospective, concurrent, and retrospective review decisions. No pended or incomplete authorization requests will be reviewed. For participants who find the same responses on the first 8 cases as the same response on the original review will receive a score of 100% and no further review is required. For participants that did not find the decision to be the same as the original review on the first 8 cases, the entire sample will be required to be reviewed. The compliance standards will apply.

C. Licensed/Non-Licensed Staff:
   1. If the staff member performs a combination of duties and/or has multiple groups the process for, a percentage of referrals will be pulled for each activity or group.

   2. Each case/authorization will be audited using the measurement tool against the hard paper copy or computer database or a combination of both.

   3. The total score per case will equal 100% with adjustments made for non-applicable standards.

   4. If the employee meets the compliance standards listed above, he or she will then not be reviewed until the following year. If the employee has a change in duties, he or she will be reviewed again in that probationary period.

D. Physicians:
   1. The random de-identified selection will be presented for review using the 8/30 Methodology.

   2. The overall findings will be scored. Any score under 95% will be discussed.

   3. The Medical Director will meet with and re-educate physicians whose scores are below 95%

E. The designated auditor will tally the results and assign an overall score.

F. All employees will receive a copy of their own audit results, including feedback and areas to improve. In the event that the results are less than 95%, a corrective action plan will be developed including the planned date for review.

G. The department on the whole will review a composite score of all findings for additional input, training needs, development and identification of needs for policy revision.

H. A report of composite scores will be generated and maintained in a file. This will be made available for health plan auditors.

FORMS:

Inter-rater Reliability Form – Physician
Inter-rater Reliability Form - Nurse
Inter-rater Reliability Form - staff

REFERENCES:

NCQA UM 2 Clinical Criteria for UM Decisions

SUBJECT: Appeals Process **Policy #:** UM12
DEPARTMENT: Utilization Management

Effective Date: June 1, 1997
Last Revision Date: December 30th, 2024,
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To outline the policy and procedure for a reconsideration of a denied service from pre-service, post service, expedited or external requests on behalf of a member or provider.

POLICY:

NON-DELEGATION:

When the appeals process is not delegated by the health plan contract, all 1st and 2nd level appeals as defined under this policy will be sent to the health plan. If the request is made verbally, the member will be immediately directed to their Health Plan's Member Services Department. If the request was received by the Medical Group in writing, it will be forwarded to the health plan according to each plan's rules and timeliness requirements. For most plans, Standard appeals will be sent within 24 hours of receipt and Expedited Appeals will be sent within 2 hours of receipt (including weekends and holidays).

Upon request from the Health Plan for additional information or medical records, Member Services will forward any requested information to the plan within 24 hours of receipt of request for Standard and within 2 hours of receipt for Expedited. A log will be maintained to document all dates requested and dates submitted.

Requests for effectuation will be returned to the health plan within 24 hours of request for Standard Appeals and within 2 hours of request for Expedited Appeals.

When not delegated, the health plan is responsible to:

1. Allow at least 65 calendar days after notification of the denial for the member to file an appeal.
2. Document the substance of a pre-service appeal and any actions taken.
3. Perform the full investigation of the substance of the appeal, including any aspects of clinical care involved
4. Allow opportunity for the member to submit written comments, documents or other information relating to the appeal.
5. Send notification to the member about further appeal rights.
6. Allow an authorized representative to act on behalf of the members.
7. Continue coverage pending the outcome of an appeal.
8. Accept a request for a standard or expedited level 1 appeal after the 65-day timeframe if the filing party shows good cause.

DELEGATION:

The Member Services Department works with the Utilization Department to inform, document, track and report formal grievances to the Utilization and Quality Management Committees and the health plan.

Member appeals can be verbal or in writing. Members also have the right to be represented by anyone they choose, including an Attorney.

The provider's appeals must be in writing.

Standard appeals must be received within sixty (65) calendar days of the receipt of denial notification or may be dismissed for non-compliance with the appeals policy.

Standard appeal decisions are made with notification to the member and provider within 30 days. A 15-day extension may be permitted beyond the 30-day limit, if circumstances beyond medical group's control prohibit the determination.

If the member, his or her representative or a physician (plan or non-plan) feels the member's health could be harmed by waiting for standard appeal process, the member, his or her representative or a physician can request an Expedited Appeal.

Expedited appeals are made with notification to the member and provider within 72 hours, including weekends and holidays. A 10-working day extension may be permitted beyond the 72 hours only if the extension of time benefits the member. For example, if diagnostic tests or additional information is needed prior to making the determination.

A written notification of the extension and need for delay will be provided to the member or provider prior to the initial standard (30-day) or expedited (72-hour) deadline.

In some cases, the IPA may not be delegated for Expedited Appeals. When this is the case, the Appeal will be faxed to the health plan immediately upon receipt. A phone call will be made to ensure that the Appeal was received by the plan. The Appeal will be logged awaiting the response from the Health Plan. If no response is received from the Health Plan within 72 hours, the Health Plan will be contacted for written documentation for reason of delay and planned date for response.

Responses to Expedited or Standard Appeals, either from the health plan or the group, are to be clear and concise. If the grievance is about a clinical issue, the criteria used and the clinical reasons for the decision are included. The members are to receive written notice within 2 days of the decision.

Appeals will be tracked and reported on the appeal log. The documentation tracked on the log will include date and hour[1] appeal received, date decision made, date member and provider notified, determination and reason for determination.

Expedited appeals are identified separately from standard appeals in the tracking log and health plan reporting.

Logs will be presented monthly to the Utilization and Quality Management Committees. All appeal activity is forwarded to the health plans by the 5th of each month, according to contractual requirement.

[1] HCFA Medicare requirement for 72 hour Expedited Appeals.

When delegated, Members will be given opportunity to submit written comments, documents or other information relating to the appeal and will be notified of further appeal rights.

All paperwork pertaining to the UM decision to deny the authorization or claim will be attached to the appeal request, including details documenting the substance of a pre-service appeal and any actions taken**.** If the IPA receives a request from the health plan to respond to an appeal being processed, the IPA will comply with the time frame for review. This may include contacting the provider and requesting additional medical information not previously reviewed to assist in the health plan determination.

The group will continue coverage during the appeal process.

QUALITY OF CARE: Situations involving quality of care are referred to the QM Committee and QM Director. QI Activities to improve outcomes of the service or clinical care as a result of an appeal are the responsibility of the Quality Management Committee.

DEFINITIONS:

Good Cause: CMS has listed the following as examples as of circumstances where good cause exception for late filing may exist. Good cause exception for late filing may exist when; the member did not receive the notice for the adverse initial determination, or they received it late; the member was seriously ill, which prevented a timely appeal, there was a death or serious illness in the party's immediate family, an accident (e.g., a natural or man-made disaster) caused important records to be destroyed, documentation was difficult to locate within the time limits, the member had incorrect or incomplete information concerning the level 1 appeal
l process, the member lacked capacity to understand the timeframe for filing a level 1 appeal: or the party sent the request to an incorrect address, in good faith, within the time limit and the request did not reach the plan until after the time period had expired, the delay is a result of the additional time required to produce member documents in an accessible format (for example, large print or Braille), or the delay is the result of an individual having sought and received help from an auxiliary resource (such as a State Health Insurance Assistance Program (SHIP) or senior center), on account of his or her disability, in order to be able to file the appeal.

Appeal (preservice, post service and external) – the formal grievance process whereby a member or a provider exercises his or her right to contest and request a reversal of an authorization or claim decision to deny or partially deny a benefit of service.

> 1st Level Appeal (also known as Complaint or Grievance): a member or provider request to reverse a previous decision to deny a service or claim.
>
> 2nd Level Appeal: a member or provider request to reverse a 1st level appeal determination to uphold the denial decision.

Expedited Appeal – if the member's health or ability to function could be seriously harmed by waiting for a standard decision, the decision is made and processed back to the member in 72 hours. This process does not apply to denial of payment for services already received.

Health Plan Regulatory Appeals - At any time, the provider or member can file an appeal directly with the health plan, Department of Managed Health Care (D.O.H.C.), Health Care Financing Administrator (HCFA)

contractor (i.e., CHDR), or through the State Department of Social Services Office of Chief Referee as determined by line of business or health plan contract.

PROCEDURE:

First Level Appeals

A. An appeal is received by the Member Services Department via telephone, fax, or letter from the member or his or her representative. The member's provider may act on the member's behalf to assist in filing the appeal.

B. The appeal is logged including date and hour of receipt.

C. A letter is sent within 5 working days, acknowledging the member or provider appeal.

D. A full investigation of the clinical care, including previous actions will be gathered for review.

E. The Medical Director reviews the appeal. If the Medical Director was involved in the initial determination, the QM Chairperson and/or another person from the UM Committee will be assigned to conduct the review. In either case, the person(s) reviewing the appeal will have the appropriate expertise and experience managing the medical condition, procedure or treatment being appealed.

F. Once the determination is made, that date becomes the closure date. All necessary adjustments are made if the new determination is a modification of the original decision.

G. The member and provider are notified within one working day of the determination. The notification must include:

1. A clear reason for the determination, including explanation of medical necessity or benefit limitation.
2. The right to appeal.
3. The appropriate address to file a 2nd level appeal.

H. All upheld 1st level appeals are sent to the health plan within one working day of the determination. All clinical information used to deny and uphold the decision will be sent with the health plan notification.

Second Level Appeals

A. Determination to uphold the 1st level appeal denial may be appealed through the 2nd level appeal process. This is considered a non-delegated medical group function. Refer to the health plan provider manual and or policy guidelines for the procedure.

FORMS:
Not applicable

REFERENCES:
CMS Medicare Appeals and Grievances 50.2.2 Request for Expedited Level 1 Appeals
CMS Medicare Appeals and Grievances 50.3 Good Cause Exceptions

SUBJECT: Service Denial Process **Policy #:** UM11
DEPARTMENT: Utilization Management

Effective Date: June 16, 1997
Last Revision Date: July 2nd, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To consistently inform providers and members of denied requests for service and ensure notice of their rights to appeal.

POLICY:

Appropriately licensed professionals will supervise all medical necessity decisions. Medical Director or Physician Reviewer will be responsible for all medical necessity denial decisions utilizing the hierarchy of criteria for use. The Medical Director or physician reviewer responsible for making partial or fully adverse decisions will have expertise in reviewing the services at issue and have knowledge of Medicare coverage criteria. When multiple services are requested that are interrelated, the IPA will use the same reviewer. When services are not interrelated, decisions to deny a service will be made by a reviewer with appropriate expertise.

All Members, their authorized representatives (when known), the Prescribing Provider, and Primary Care Physician (PCP) will be notified when a submitted authorization is Denied, Modified or Deferred or when the IPA Reduces, Suspends or Terminates a previously approved covered service.

For integrated plans when the IPA reduces, suspends, or terminates a previously approved covered service the IPA will provide the member with an integrated coverage determination at least (10) calendar days in advance of the effective date of the adverse determination and will notify the member, their authorized representatives, the prescribing provider, and primary care physician (10) days prior to the date of action.

All letters for Denial, Modification or Deferral will be sent to members in a timely manner as identified in policy UM4, and according to the timeliness grids attached to UM4 and this policy. The denial letters utilized will be the most recent approved templates received from the member's corresponding health plan. The denial letter will contain:

1. The specific reasons for the denial in easily understandable language, 6th grade reading level or less, and
2. Diagnosis and clinical information required for the service to have been covered.
3. Criteria utilized in making the decision; and notification that the member can obtain a copy of the actual benefit provision, benefit, or other similar criterion on which the denial decision was based.
4. Health Plan Appeal language.

See UM/CM/CCR mailroom process for timing of outgoing mail during business week. All correspondence to Medicare members will be sent in a pre-printed envelope marked "Important plan information" in 12-point font on the front of envelope. CMS allows for pre-printed labels or ink stamp.

The Utilization Management staff will work with other departments, including quality management, claims and member services, to ensure that accurate information is given to the members and providers when a denial of service is processed.

Some of the reasons a service denial occurs are:

- The service is not a covered benefit.
- The member is not eligible, or the benefit has been exhausted.
- The treating provider is not contracted with the IPA/Medical Group (which may sometimes result in modification of request to contracted provider in lieu of denial of service).
- The service can be provided by the Primary Care Physician
- The service is not medically necessary.
- The service was non-urgent and was not prior authorized.
- The service was modified in the treatment plan.

Ambulatory services that are clearly non-covered and do not meet medical necessity criteria may be denied prospectively, concurrently, and retrospectively in accordance with benefit plan description. These services are reviewed by a physician.

When the IPA is making a coverage determination on a Medicare covered item or service with fully established coverage criteria, the IPA cannot deny coverage of the item or service based on internal, proprietary, or external clinical criteria that are not found in traditional coverage policies.

Ambulatory services that are questionable regarding the covered benefits, medical necessity or appropriateness require a Medical Director's intervention and review determination.

All denials, deferrals, modifications and terminations of service will be handled in a consistent and timely manner.

All denials of care will be reviewed by the UM Committee at the scheduled UM Committee Meetings.

Physician Reviewer will have appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. At any time, the Medical Director or Physician Reviewer may contact a Board-Certified specialist to assist in making decisions of medical necessity. This may be accomplished by telephone or face-to-face discussion of the case.

If behavioral health referrals are delegated to the IPA, a Psychiatrist, doctor level clinical psychologist, or certified addiction medical specialist will review any denial of behavior health care that is based upon medical necessity, except in cases of psychological testing, which shall be rendered by a qualified psychologist.

Members and Providers have the right to appeal a denial, modification, delay, or termination determinations and are informed of their appeal right in the denial, modification, delay, or service termination letter. The Denial Notice will include the timeframe to file a formal Appeal, the process for filing an appeal including opportunity to submit written comments or supply documents in support of their appeal request and the timeframe for when an appeal decision will be rendered. It may also include the member's right to be represented by anyone they choose, including an Attorney; process for obtaining additional help from an applicable office of health insurance consumer assistance or Ombudsman and the contact information. It will also detail the process for expedited appeals and, where applicable, the process for an external review which can occur concurrently with the internal appeals process for urgent and ongoing treatment.

The Commercial template from the plan will include:

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-XXX-XXX-XXXX or TTY/TDD users may call 1-XXX-XXX-XXXX and use your health plans grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-XXX-XXX-XXXX) and a TDD line (1-XXX-XXX-XXXX) for the hearing and speech impaired. The department's Internet Web site www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.
>
> A statement of the member's right to bring a civil action may include the following:
>
> 1. ERISA
>   You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your Health Plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employer's benefit plan administrator to determine if your employee's benefit plan is governed by ERISA. Additionally, you and your Health Plan may have other voluntary alternative dispute resolution options, such as mediation.
> 2. Diagnosis/Treatment Codes
>   "Member can obtain, upon request, a written statement describing the availability of diagnosis and treatment codes and their corresponding meaning."
> 3. Consumer Resources
>   A statement of additional consumer resources may include:
>   "Other resources to help you: Do you have questions about your appeal rights or this notice? Need help with an appeal? You can get help from the Consumer Assistance Program (CAP) in California.
>
>   California Department of Managed Health Care Help Center
>   Toll Free: 1-888-466-2219 TDD/TTY 1-877-688-9891
>   http://www.healthhelp.ca.gov

In addition, for Medi-Cal denials letter will include in the denial decision paragraph, the product name of criteria utilized, policy/procedure or guideline and title of the specific criteria used to make the decision and specified Title 22 regulation citation, where required.

All attempts will be made to send the member a denial letter in their primary language. For translation of vital documents [i.e., denial letters, etc.] the member will be referred to their health plan for assistance. LAP Notice of Translation, approved by the DMHC, will accompany UM denial notifications, including modifications or UM delay notifications for additional information or expert review. Tailored strategies for communication barriers will be addressed on a case-by-case basis.

A denial letter is not required when there is a request for a drug and a drug identical in chemical composition, dosage, and bioequivalence is approved (e.g., when a generic drug is substituted for the brand name drug).

Members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criteria used in their denial determination. Criteria is made available to all providers, members, and the public upon any written or verbal request. The information will be provided in a timely manner either via fax or mailing by contacting the UM Department at (714) 947-8600. Per DHCS APL 17-006, all NOA records will be available at no cost to Medi-Cal members.

Members have the right to request an Independent Medical Review (IMR) and Medi-Cal members may request a State Fair Hearing for any referral that is denied, modified, delayed, or terminated because of lack of medical necessity, the denial letter language will explain how to access this process.

Medi-Cal members have a right to Aid Paid Pending when they have filed a timely (within 10 calendar days of date of mailing) State Fair Hearing request as a result of notification to Terminate, Suspend or Reduce an existing authorized service.

Documentation of denial activity will be maintained by the UM department for tracking and reporting purposes. An electronic copy of all denial activity is attached to the member record in the system.

Health Plans may overturn a group's denial decision. When this occurs, the group must log this overturn on an UM Appeals log. The overturn will occur within 2 days of the notice or sooner inconsideration of a member's health condition, and a copy of the now "approved" referral letter will be sent to the Health Plan and to the member.

DEFINITIONS:

Aid Paid Pending: Continuation of covered services for a member who has filed a timely request (within 10 days) for a State Fair Hearing as a result of notification of intent to Terminate, Suspend or Reduce an existing authorized service.

Authorization: Approval granted by designated licensed staff in advance of rendering of a service, unless otherwise specifically stated, after appropriate medical, dental, or other review.

Covered Services: Those services set forth in Title 22 of the California Code of Regulations, which are described in health plan contracts, are medically necessary and are included in the Capitation Rate.

Delay: Action taken by an IPA to postpone a decision regarding a request for authorization of a covered service.

Denial/Deny: Action taken by an IPA to reject approval of a covered service that requires prior authorization.

Medical Necessity for Medicare Services: Reasonable and necessary services for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body members or otherwise medically necessary under 42 CFR §1395(y).

Medical Necessity for Medi-Cal Services: Reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate server pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code Regulations (CCR) Section 51303.

Modification/Modify: Action taken by an IPA to approve in part a request for a covered service requiring prior authorization, and to withhold or change in some way a portion of the covered service requested.

Primary Care Physician or PCP: A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

Prior Authorization: See "Authorization"

Provider: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, or other person or institution that furnishes health care items or services.

Specialist Physician: A physician whose area of expertise is limited to one area of practice, such as Orthopedics, Ophthalmology. Provider does not provide initial and primary care.

Termination/Terminate: Action taken by an IPA to discontinue a previously approved period of coverage of a covered service that requires prior authorization.

PROCEDURE:

A. The UM Coordinator completes the initial referral processing in accordance with the Referral Authorization Process.

B. If in the UM Coordinator's review, it is noted that the member is no longer eligible with the health plan, or the service requested is not clearly a covered benefit:

    1. For non-eligible members, UM Coordinator will document ineligibility and refer cases back to the Primary Care Physician.
    2. For services that are clearly not covered under a member's plan, the UM Coordinator will document the finding, have reviewed by the Medical Director/Physician Reviewer for any medical necessity and process as a benefit denial.

C. The Medical Director, using the hierarchy of criteria, will review referrals as described in the Referral Authorization Process and render all decisions to either approve, modify, or deny.

D. The Medical Director review will be completed within the required turnaround time for the member's plan requirements for referral processing unless additional information is necessary for completion.

E. If additional information is required before a final determination can be made, the Medical Director may confer directly with the requesting physician, have another specialty physician consultant review the case or request additional documentation of clinical information through the UM Coordinator. A Delay letter will be sent to the member according to the applicable line of business UM Timeliness Standards Guidelines (attached).

F. Only the physician reviewer or Medical Director has authority to deny, modified, delay or terminate services for medical necessity.

G. All decisions are documented and signed by the physician, including discussions with any physician advisors or the treating providers. The physician signature stamp may be used by the UM Manager or UM Supervisor when the Medical Director is contacted by phone and there is no fax machine available to send the letter for signature.

H. The reason for denial, review criteria and suggested clinically equivalent or alternate service must be clearly stated in the notes and in the denial letter. The denial reason in the letter will match the Medical Director's denial rationale documented in the case file. For denials for services that are not a covered benefit, the section of Evidence of Coverage must be cited on the denial letter. For all lines of business, services denied that do not meet medical necessity or benefit plan description will be included in the denial letter issued to the member and provider.

I. When a member is re-directed to an in-network provider, the modification notice will contain a reference to the member's health plan benefit, diagnosis, service requested, name of provider not in-network, indication that the service or items is/are covered in-network and by whom.

J. If the Medical Director's review delays the determination for more than five business days, the referral will be Pended for additional information, and Delay letters will be sent to the provider and the member according to applicable ICE UM Timeliness Standards (attached).

K. Once the final determination of a denial of service is made, the determination is communicated within one business day to the member and provider. If a decision is communicated verbally, a written or electronic confirmation (or letter) will be sent within one working day of the original notification.

L. The Primary Care Physician will be notified of the denial after the determination has been made in writing via fax following ICE notification requirements. The Primary Care Physician and the requesting physician will be provided an opportunity to discuss a modified or denied case with the Medical Director or physician reviewer who rendered decision by telephone or face to face.

M. The telephone and/or pager number of the Medical Director is available to the providers in the Provider Directory. In addition, the referral authorization will include the name and number of the physician reviewer to call for further discussion. Unless the referral is stat or urgent, the physician reviewer will be available during business hours. If stat or urgent, the physician will be paged.

N. The Medical Director or physician reviewer will be responsible to ensure that the discussion is noted in the referral authorization request including date and time of discussion.

O. The determination of referrals is documented by the UM Coordinator and entered into the computerized authorization system.

P. The appropriate denial letter is sent to the member (verifying health plan and line of business specifics). To address members who may be Limited English Proficient (LEP), the UM Coordinator will contact the member's Primary Care Physician to assess the member's primary language, if not already listed on the referral. Once the primary language is determined, all attempts will be made to provide a denial letter and denial explanation in that language. In some instances, where the letter in the member's primary language is not currently available, the Primary Care Physician's office may contact the patient and request they come in to discuss the denial of service. When that occurs, a copy of the English version of the denial letter will be faxed to the PCP as well as mailed to the member with an attachment of how to obtain assistance with interpretation. When issuing a denial for integrated organization determination the IPA will use a specialized integrated notice when notifying the member of the determination.

In addition, LAP Notice of Translation, approved by the DMHC, will accompany UM denial notifications, including modifications or UM delay notifications for additional information or expert review.

Q. The denial letters must contain the members right to appeal within 90 days of notice and process to do so.
    1. The denial letter will also include the number to access an Independent Medical Review, where applicable under the member's plan, if the patient chooses.
    2. The Medi-Cal denial letter will have information regarding the State Fair Hearing process.

R. The Provider will be notified of his right to request a first level appeal from the IPA. The Provider will send his request for appeal in writing within 90 days of the denial decision, including any supporting documentation.

    1. <u>For Non-Delegated Plans –</u> the appeal is to be sent to the appropriate health plan immediately upon receipt. The member or provider may contact HSMSO's Utilization Management Department for the address of the involved health plan.

    2. <u>For Delegated Plans</u>:

        a) A physician who was not involved in the initial denial must make the redetermination/reconsideration when the initial decision involved a determination of medical necessity. The request for an appeal may be taken to the UM Committee for review, ensuring a response to the member or provider within 30 days from receipt. If it is determined that the Committee will not meet within a time period to allow adherence to the 30-day timeline, the UM or QM Chairperson or his/her designee will review the appeal and provide a response to the provider.
        b) After the Committee has rendered their decision, the member or provider will be contacted within 24 hours of the decision with the Committee's findings.
        c) If the committee agreed to uphold the initial denial, the member or provider will be given instructions on how to request a 2nd level appeal at the health plan level, following health plan guidelines.
        d) Expedited appeals are made with notification to the member and provider within 72 hours, including weekends and holidays.

S. Copies of all denial letters are sent to the Primary Care Physician and the member's health plan. A copy is also kept with the authorization request.

T. A report of service denials can be run for reporting needs and an electronic copy of the denial will be attached the referral.

U. All medical necessity Denials will be reviewed by the UM Committee for Inter-rater Reliability of denial decisions.

V. Notification Timelines:

    1. Medi-Cal: See attached Utilization Management Timeliness Standards, Medi-Cal Managed Care - California

2. Medicare: See attached Utilization Management Timeliness Standards , Centers for Medicare and Medicaid Services (CMS)

W. Health Plan review of Denials

1. The UM Department will submit denial logs to the health plans on a monthly or quarterly basis according to the requirements of each plan.

2. As part of the health plan's oversight and/or in review of an Appeal/Grievance, the plan may request a copy of a denied referral and supporting documentation. Information will be submitted to the health plan within the health plan stated timeframe and as expeditiously as the member's condition may require.

3. Upon notification of a health plan's decision to overturn a denial of services, the Medical Director/Physician Reviewer will be notified of the Health Plans decision. The Medical Director may have the opportunity to discuss the decision with the health plan for mitigation and/or educational opportunities.

4. The referral will be changed to approved and notifications sent within 24 hours.

FORMS:
Referral Authorization Worksheet
Denial letters, by plan – (Medi-Cal, Commercial and Medicare)

REFERENCES:
California Health and Safety Code 1367.01 (e), 1363.5 (b)(4), 1367,01 (h)(4), 1374.30 (i), and 1368 (a)(4)
Title 22, California Code of Regulations
ICE Utilization Management Timeliness Standards – Medi-Cal, Medicare, Commercial – ICE
NCQA UM6
42CFR 422.631
Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans

SUBJECT: Retrospective Referral Process **Policy #:** UM10
DEPARTMENT: Utilization Management

Effective Date: June 16, 1997
Last Revision Date: December 19th, 2023
Last Review: January 2026

SCOPE

This policy applies to all lines of business.

PURPOSE:

To provide a mechanism for processing ambulatory and facility authorization referral requests on a retrospective basis.

POLICY:

The UM Referral Authorization Process requires that all referrals are to be pre-authorized for all routine and non-urgent cases. Exceptions are made in emergent and urgent situations. In those instances, the referral is reviewed retrospectively for medical necessity.

For Medicare and Medicare Advantage retroactive services, medical necessity will be reviewed at the times of claims submission.

The UM Committee will retrospectively review a case including any chart notes provided and make determination on all cases which require authorization. All retrospective referral review will be completed within 30 calendar days of receipt of the request.

Retroactive referrals may have the following outcome:

- Approval – (Refer to Authorization Policy UM4)
- Denial – (Refer to Denial Policy UM11)
- Approval and Educate – Utilized when services are retrospectively reviewed and authorized, and the following notation is added: "prior authorization requirement for future needs". This results in education to the member and/or the provider on the referral process. Example of use: emergency room use for non-urgent visits.

DEFINITIONS:

Retrospective Review: An assessment of appropriate medical services after services have been provided.

PROCEDURE:

A. Retrospective referrals are processed by the UM Coordinators in the same manner as outlined in the UM Referral Authorization Process.

B. The Medical Director makes the determination to approve or deny a retrospective case referral within 30 business days of the receipt of complete information. Notification letters to members and provider will be sent the same day.

C. For inpatient referrals where the Concurrent Review Nurse is notified of an admission after the admission date, the referral is to be marked as Retroactive and the case will be reviewed according to the Concurrent Review policy.

D. When it is necessary to obtain more information to complete a retroactive review, the referral may be extended for additional information up to 15 calendar days under the following conditions.

1. Before the end of the time frame, the group asks the member or the member's representative for the information necessary to make the decision.

2. The group gives the member or the member's authorized representative at least 45 calendar days to provide the information

3.The extension period, within which a decision must be made, begins on the sooner of:

a. The date when the group receives the member's response.
b. The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.
c. If the timeframe is extended, the case will be open for 15 calendar days.
d. After the 15-calendar day timeframe, if no documentation is received, the case review will be determined based upon the available information.

Claims that are determined to require authorization are also reviewed retrospectively by the UM Coordinator & Medical Director.

2. EXCEPTION: All "911" calls and Emergency triage will not be retrospectively denied or reviewed for medical necessity if the care meets the *prudent layperson* criteria under the definition "Emergency Medical Condition"[1] or if the care was authorized by an authorized IPA provider.

FORMS:

Referral Authorization Worksheet

REFERENCES:
CA Health & Safety Code 1367.01 (b) (c), (i)
NCQA UM 1
NCQA UM 5 Timeliness of UM Decisions Factor 6 Post service Request

[1] AB984 – 1/1/99 Emergency Services

SUBJECT: Retrospective Referral Process **Policy #:** UM10
DEPARTMENT: Utilization Management

Effective Date: June 16, 1997
Last Revision Date: May 2015
Last Review: January 2023

SCOPE

This policy applies to all lines of business.

PURPOSE:

To provide a mechanism for processing ambulatory and facility authorization referral requests on a retrospective basis.

POLICY:

The UM Referral Authorization Process requires that all referrals are to be pre-authorized for all routine and non-urgent cases. Exceptions are made in emergent and urgent situations. In those instances, the referral is reviewed retrospectively for medical necessity.

For Medicare and Medicare Advantage retroactive services, medical necessity will be reviewed at the times of claims submission.

The UM Committee will retrospectively review a case including any chart notes provided and make determination on all cases which require authorization. All retrospective referral review will be completed within 30 calendar days of receipt.

Retroactive referrals may have the following outcome:

- Approval – (Refer to Authorization Policy UM4)
- Denial – (Refer to Denial Policy UM11)
- Approval and Educate – Utilized when services are retrospectively reviewed and authorized, and the following notation is added: "prior authorization requirement for future needs". This results in education to the member and/or the provider on the referral process. Example of use: emergency room use for non-urgent visits.

DEFINITIONS:

Retrospective Review: An assessment of appropriate medical services after services have been provided.

PROCEDURE:

A. Retrospective referrals are processed by the UM Coordinators in the same manner as outlined in the UM Referral Authorization Process.

B. The Medical Director makes the determination to approve or deny a retrospective case referral within 30 business days of the receipt of complete information. Notification letters to member and provider will be sent the same day.

C. For inpatient referrals where the Concurrent Review Nurse is notified of an admission after the admission date, the referral is to be marked as Retroactive and the case will be reviewed according to the Concurrent Review policy.

D. When it is necessary to obtain more information to complete a retroactive review, the referral may be pended for additional information.

1. If pended, the case will be open for two more weeks.
2. After the two-week time frame, if no documentation is received, the case review will be determined based upon the available information.

E. Claims that are determined to require authorization are also reviewed retrospectively by the UM Coordinator & Medical Director.

1. EXCEPTION: All "911" calls and Emergency triage will not be retrospectively denied or reviewed for medical necessity if the care meets the *prudent layperson* criteria under the definition "Emergency Medical Condition"[1] or if the care was authorized by an authorized IPA provider.

FORMS:

Referral Authorization Worksheet

REFERENCES:
CA Health & Safety Code 1367.01 (b) (c), (i)
NCQA UM 1

[1] AB984 – 1/1/99 Emergency Services

Policy:	EE.1103
Title:	**Provider Network Training**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	*/s/ Michael Hunn 08/21/2025*
Effective Date:	03/01/2001
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

I. PURPOSE

This policy outlines the education and training requirements for Newly Contracted Provider and annual training provided by CalOptima Health and its Health Networks to medical, behavioral health, and Long-Term Services and Support (LTSS) Providers (hereinafter referred to as "Network Providers"), any Provider that interacts with CalOptima Health Members and Subcontractors who serve CalOptima Health's Members participating in CalOptima Health Medi-Cal, OneCare and Program of All-Inclusive Care for the Elderly (PACE) programs, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima Health shall train all CalOptima Health Direct-Administrative and CalOptima Health Community Network participating Network Providers and Subcontractors for Medi-Cal, OneCare and PACE programs in accordance with this Policy.

1. Training will be conducted online or in-person;

2. Training will be reviewed by CalOptima Health's Quality Improvement Health Equity Committee (QIHEC) and Regulatory Affairs and Compliance Department on an annual basis to ensure consistency and accuracy with DHCS requirements and CalOptima Health's policies and procedures; and

3. Records of attendance will be maintained to validate that Network Providers received training on a bi-annual basis.

B. A Health Network shall ensure training of Health Network staff that interact with Members in accordance with this Policy.

1. In compliance with Title 42 Code of Federal Regulations (CFR) Section 438.236(b), CalOptima Health shall ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of CalOptima Health's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, CalOptima Health shall disseminate their practice guidelines to all affected Providers.

C. Network Providers: CalOptima Health or a Health Network shall provide Newly Contracted Provider and annual training to Network Providers who serve CalOptima Health's Members participating in CalOptima Health's health care programs, in accordance with applicable DHCS and CMS requirements and Section III.A. of this Policy.

1. CalOptima Health shall require disability and cultural competency training for its Network Providers in accordance with Section III.C. of this Policy.

2. CalOptima Health shall disseminate practice guidelines to all Network Providers and ensure guidelines are reviewed and updated periodically as appropriate.

3. CalOptima Health shall ensure practice guidelines are based on valid and reliable clinical evidence or a consensus of Network Providers in a particular field and consider the needs of CalOptima Health Members in consultation with Network Providers.

4. CalOptima Health and Health Networks shall develop and implement a process to provide information to Network Providers and to train providers on a continuing basis regarding clinical protocols and evidenced-based practice guidelines and DHCS developed cultural awareness and sensitivity instructions for Seniors and Persons with Disabilities (SPD).

    a. This process shall include an educational program for Network Providers regarding health needs specific to SPD Members that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

    b. Individuals covered by this requirement include, but are not limited to, CalOptima Health and Health Network staff that interact with Members, as applicable, contracted CalOptima Health and Health Network Primary Care Physicians (PCPs), specialists who serve a high-volume of SPD Members, and speech, occupational, and physical therapists, in accordance with Welfare and Institutions Code section 14182(b)(5).

5. CalOptima Health and Health Networks shall develop and disseminate annual diversity, health equity and inclusion training related to Members including completion of required Continuing Medical Education on cultural competency and implicit bias.

D. Designated County Agencies: CalOptima Health shall provide training to staff of partner designated county agencies interacting with Members, as applicable, and in accordance with Section III.B.1. of this Policy.

E. For Out-of-Network Providers who will not receive Network Provider training, CalOptima Health or a Health Network shall develop and implement a process to provide the Out-of-Network Provider with grievance processes, clinical protocols, evidence-based practice guidelines, and the Special Needs Plan (SNP) Model of Care. CalOptima Health or a Health Network shall arrange to provide these protocols and guidelines at the time that CalOptima Health or a Health Network enters into an agreement with an Out-of-Network Provider.

1. CalOptima Health shall require disability and cultural competency training for its Network Providers in accordance with Section III.C. of this Policy.

F. PACE Providers shall complete training prior to commencement of services to PACE Participants.

G. CalOptima Health shall review Health Network reports to ensure compliance with Newly Contracted Provider and annual training.

H. CalOptima Health and each Health Network shall make a Provider Manual accessible to all Network Providers and Subcontractors.

I. Training attestations shall be required as provided in Sections III.E-F. of this Policy.

J. CalOptima Health and Health Networks shall ensure that Network Providers and Subcontractors complete the self-registration process, are trained on how to operate the Electronic Visit Verification (EVV) system and have gained access to the state-sponsored EVV system and EVV Aggregator as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements.

    1. CalOptima Health and Health Networks shall supply Network Providers with technical assistance and training on EVV compliance.

K. CalOptima Health shall ensure the required DHCS Dementia Care Aware Cognitive Health Assessment training is completed prior to conducting annual cognitive assessments for Medi-Cal Members as outlined in the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older.

    1. CalOptima Health shall ensure that Network Providers have completed the required training prior to claim submission and payment.

L. CalOptima Health and Health Networks shall ensure Network Providers complete Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) training no less than every two (2) years, in accordance with DHCS APL 23-005: Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21.

    1. At minimum, CalOptima Health and Health Networks shall use the training program developed by DHCS to promote a more uniform and shared understanding of the EPSDT benefit. The training program refers to EPSDT as Medi-Cal for Kids & Teens.

    2. On an annual basis, by February15th of each calendar year, CalOptima Health shall submit a comprehensive plan to DHCS ensuring all Network Providers receive proper education and training regarding EPSDT.

        a. The annual comprehensive plan shall include an attestation that the Provider Network is in compliance with the EPSDT training requirements and include a list of Network Providers who have completed training within the past twelve (12) months.

        b. The annual comprehensive plan shall include how many Network Providers serve Members under the age of twenty-one (21), how many Network Providers are not in compliance, and an outline of the steps CalOptima Health has taken to ensure Network Providers are fully compliant.

    3. If CalOptima Health chooses to augment the training with additional information, CalOptima Health shall submit training materials with edits highlighted to DHCS for review and approval prior to use.

M. CalOptima Health and Health Networks shall ensure Network Providers, Subcontractors and Downstream Subcontractors are trained on complying with valid Advance Directives, in accordance with 42 CFR Sections 422.128 and 438.3(j).

N. CalOptima Health shall pay all claims within contractually mandated statutory timeframes in accordance with CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible, DHCS APL 23-020: Requirements for Timely Payment of Claims.

1. Network Providers have an obligation to refrain from billing Members for Covered Services, even if CalOptima Health pays late or denies payment for a claim.

O. CalOptima Health shall be responsible for ensuring Subcontractors and Network Providers comply with all appliable state and federal laws and regulations, contract requirements and other DHCS guidance, including APLs, related Policy Guides and Policy Letters in accordance with DHCS APL 23-030: Medi-Cal Justice-involved Reentry Initiative-related State Guidance.

1. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance.

P. For purposes of this policy, the Newly Contracted Provider training and annual training are referred to as separate and distinct trainings due to the timeframe requirements for each training. The content included in the Newly Contracted Provider training and annual training is the same.

III. PROCEDURE

A. Newly Contracted Provider Training

1. Newly Contracted Provider and Annual Training for Network Providers shall be provided as follows:

   a. CalOptima Health or Health Network shall initiate training for all Network Providers and Subcontractors no later than ten (10) business days and shall complete the training within thirty (30) calendar days of placing them on Active Status.

   b. Training materials shall include, but are not limited to the following:

      i. Training presentation; and

      ii. Training attestation.

2. Health Networks shall attest that appropriate Health Network staff have been educated and trained, in accordance with the DHCS cultural awareness and sensitivity instructions for SPDs in accordance with Welfare and Institutions Code section 14182(b)(5).

3. CalOptima Health shall provide training on key elements of operating a successful program for administering Managed Long-Term Services and Supports (MLTSS).

4. Upon completion of the training, the Network Provider and other staff deemed appropriate by CalOptima Health shall sign an acknowledgement notice and shall return the signed acknowledgement notice to CalOptima Health or the Health Network.

5. If CalOptima Health or a Health Network is unable to complete the training within the thirty (30) calendar days requirement, CalOptima Health or Health Network shall send materials to the Network Provider's office, and document reasons and actions taken due to non-completion of the training.

6. CalOptima Health and its Health Networks shall track completion of the Network Provider's training, including the date of completion of the training.

7. CalOptima Health or a Health Network shall retain training records for a period of at least ten (10) years.

B. Network Provider and Subcontractor Annual Training

1. CalOptima Health or Health Networks shall provide annual training for Network Providers and Subcontractors:

a. Annual training required one time per year;

b. When conducting Provider forums, meetings, outreach visits;

c. When determined necessary through notification to Providers of newly contracted product lines or updates to existing product services, performance data, such as complaint and grievance data, Member and Provider satisfaction and accessibility surveys, and practices serving a high volume of targeted populations;

d. Upon request from Providers; and

e. When CalOptima Health or one of its regulators determines that a Provider has discriminated against a CalOptima Health Member.

C. Newly Contracted Provider Training and Annual Training Material

1. As specified in Attachment A, Newly Contracted Provider training and annual training will include, but not limited to:

a. CalOptima Health programs and initiatives, including but not limited to, the California Advancing and Innovating Medi-Cal (CalAIM) and the Whole-Child Model (WCM) program;

b. CalOptima Health/Health Network operations;

c. Provider communications;

d. Member rights and responsibilities;

e. CalOptima Health policies and procedures;

f. Individual Health Education Behavioral Assessment (IHEBA) contract requirements;

g. Member benefits;

h. Claims submission, including what constitutes a clean claim or an acceptable Encounter, and payment;

i. Coordination of benefits, covered services and carved-out services;

j. Conflict resolution;

k. Critical incident reporting;

l. Member Grievance and Appeals process and requirements for Network Providers and Out-of-Network Providers;

m. Member billing restrictions;

n. Utilization Management Appeals and Provider dispute resolution process;

o. Prior authorization process;

p. Medical management and authorization requirements;

q. Customer service and cultural linguistic requirements

r. Community Based Adult Services;

s. Behavioral Health;

t. Medical management delegation and payment responsibility;

u. Medi-Cal and Medicare Member eligibility verification and disenrollment process;

v. Seniors and Persons with Disabilities (SPD) trainings;

w. Fraud, Waste, and Abuse and compliance training;

x. Model of Care;

y. Access standards;

z. Long-Term Support Services (LTSS);

aa. Authorizations, claims and Member eligibility verification process for hospitals, skilled nursing facilities and ancillary providers;

bb. Disability training information, including, but not limited to, the following:

    i. Members with chronic conditions prevalent within the population;

    ii. Awareness of personal prejudices;

    iii. Legal obligations to comply with Title II of the Americans Disability Act (ADA) and Section 504 of the Rehabilitation Act;

    iv. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;

    v. Types of barriers encountered by the target population;

    vi. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;

vii. Working with Members with mental health diagnoses and Specialty Mental Health Service (SMHS) needs, including crisis prevention and treatment;

viii. Working with Members with Substance Use Disorder (SUD) conditions, including diagnosis and treatment;

ix. Working with Members with Intellectual and Developmental Disabilities (DD);

x. Working with Children and Youth with Special Health Care Needs (CYSHCN); and

xi. HIV stigma and non-discrimination requirements.

cc. Quality improvement for health services programs;

dd. Transgender, Gender Diverse or Intersex (TGI) cultural competency training;

ee. Use of culturally competent practices including, but not limited to:

i. Diversity, Equity and Inclusion (DEI) training;

ii. Structural and institutional racism and health inequities training including the impact on Members, staff, Network Providers, Subcontractors and Downstream Subcontractors;

iii. Access and delivery of services in a culturally competent manner for all Members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56; and

iv. Health inequities and identified cultural groups including:

a) Cultural group's belief about illness and health;

b) Need for gender affirming care;

c) Methods of interacting with Providers and the health care structure;

d) Traditional home remedies and impacts of patient treatment; and

e) Language and literacy needs.

v. Pertinent information regarding Population Needs Assessment (PNA) findings and identified targeted areas;

vi. Social Drivers of Health (SDOH) and disparity impacts on Member's health care.

ff. Use of clinical practice guidelines, clinical protocols, evidence-based practices, and specific levels of quality outcomes;

gg. Electronic Visit Verification Requirements and Reporting;

hh. Doula services;

ii. Dementia care aware cognitive health assessment training;

jj. Early Periodic Screening, Diagnosis and Testing (EPSDT) training;

kk. Responsibilities for Indian Health Care Providers and American Indian Members including:

i. Cultural Humility training;

ii. Overview of Trauma-Informed Care and Historical Trauma training; and

iii. Other relevant trainings as they are developed and noted by DHCS.

D. Provider Manual Requirements

1. CalOptima Health or a Health Network shall make a Provider Manual accessible to all Network Providers, Subcontractors, and Downstream Subcontractors. The Provider Manual shall include, at a minimum, the following information:

a. Updates and revisions;

b. Overview and Model of Care;

c. CalOptima Health or Health Network contact information;

d. Member benefits covered by CalOptima Health;

e. Eligibility determination and verification process;

f. Quality improvement for health services programs;

g. Member rights and responsibilities;

h. Provider billing and reporting;

i. The Member problem resolution process;

j. The authorization process;

k. Provider cultural and linguistic requirements;

l. Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than twenty-one (21) years of age;

m. Medical Record documentation and coding requirements;

n. Regulatory and contractual requirements;

o. Vaccines for Children (VFC);

p. Other activities and services needed to assist Members in optimizing their health status, including assistance with self-management skills or techniques, preventative healthcare services, health education, and other modalities to improve health status; and

q. Provider liaison requirements as specified in Attachment B.

E. Health Network Training Materials

1. By or before January 15 of each year, Health Networks shall attest that all Health Network Providers participating with CalOptima Health and Health Networks, have completed, attested, and retained such records of Newly Contracted Provider and Annual Training located on CalOptima Health's website www.caloptima.org. Training materials to include the following:

    a. Cultural Competency Training;

    b. Disability Awareness Training;

    c. OneCare Model of Care; and

    d. Fraud, Waste and Abuse Training.

F. Training Attestations Requirements

1. Training attestations are required for:

    a. Health Networks, Network Providers, Subcontractors, and all personnel that completed CalOptima Health's training.

        i. All staff who interact or potentially interact with Medi-Cal, OneCare Members, and SPD beneficiaries;

        ii. All staff who are responsible for policies and procedures affecting Medi-Cal, OneCare members and SPD beneficiaries; and

        iii. Any other staff deemed appropriate by CalOptima Health and CMS.

    b. A Health Network, Network Provider or Subcontractor shall provide the following information on the training attestation:

        i. Organization name;

        ii. Date of completed training;

        iii. Name of individual attesting; and

        iv. Signature of individual attesting.

    c. CalOptima Health Provider Relations Department shall validate that the following requirements are met:
        i. Training for all Network Providers is initiated no later than ten (10) business days after CalOptima Health places a newly contracted Network Provider on Active Status and completed within thirty (30) calendar days of placing on Active Status;

        ii. A signature of individual attesting; and

        iii. Health Networks shall submit Newly Contracted Provider and annual training reports pursuant to CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting. The Newly Contracted Provider and annual training reports on the reporting grid reflect the reporting submission requirements.

G. Health Network and Delegated Entity Reporting

1. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima Health as required by CalOptima Health or as specified in its contract or CalOptima Health's policies and procedures in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting. Reporting requirements shall include:

    a. Data Element Reporting requirements and/or Subcontract Network Certification requirements.

2. CalOptima Health Provider Relations Department shall be accountable for:

    a. Identifying required reports;

    b. Ensuring that all reports list all applicable regulatory, contractual, and policy citations and include all required data elements;

    c. Creating templates and all applicable reporting formats, instructions, and technical guidelines;

    d. Monitoring submission and timeliness of reports;

    e. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

    f. Notifying Health Network Relations of unsuccessful follow-up attempts; and

    g. Escalating issues of continued noncompliance to the Office of Compliance.

3. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Health's Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

4. The Office of Compliance shall be responsible for the annual audit of CalOptima Health and Health Networks provider training in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

H. Verification of Network Provider Training

1. CalOptima Health and Health Networks shall verify that Network Providers attest to the Newly Contracted Provider and annual training.

2. Verification
    a. On an annual basis, CalOptima Health shall obtain Newly Contracted Provider and annual training attestations from Health Networks and CalOptima Health Community Network (CHCN).

    b. Health Networks and CHCN shall document the outcome of each attempt to obtain Newly Contracted Provider and Annual Training attestations.

    c. CalOptima Health shall monitor training attestation compliance annually in accordance with this Policy.

IV. ATTACHMENT(S)

A. Provider Network Training Descriptions
B. Provider Liaison Requirements

V. REFERENCE(S)

A. Annual Provider Training: https://www.caloptima.org/en/ForProviders/ProviderTrainings
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy GG.1619: Delegation Oversight
F. CalOptima Health Policy HH.2002: Sanctions
G. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
H. CalOptima Health Policy HH.2005: Corrective Action Plan
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection For Members With Visual Impairments
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
N. Department of Healthcare Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-025: Diversity, Equity and Inclusion Training Program Requirements
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-017: Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements
Q. Employee SNP Model of Care Training: https://www.caloptima.org/en/ForProviders/ProviderTrainings
R. Medicare Managed Care Manual, Chapter 5, Section 20.2.2, MOC 3, Element C, Factors 1 and 2
S. Newly Contracted Provider Office Education Training: https://www.caloptima.org/en/ForProviders/ProviderTrainings
T. Title 42, Code of Federal Regulations (CFR), §§422.101(f)(2)(ii), 422.128, 438.3(u), 438.206(c)(2), 438.236(c), 438.3(j) and 438.414
U. Welfare and Institutions (W&I) Code, §14182 (b)(5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/29/2010	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
03/01/2022	Department of Health Care Services (DHCS)	Approved as Submitted
03/29/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/07/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/30/2024	Department of Health Care Services (DHCS)	File and Use
12/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted

Date	Regulatory Agency	Response
05/01/2025	Department of Health Care Services (DHCS)	Approved as Submitted
08/20/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
02/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2001	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	07/01/2007	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	01/01/2009	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	11/01/2012	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal
Revised	03/01/2015	EE.1103	Primary Care Practitioner (PCP), Provider, and Health Network Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2015	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2016	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	EE.1103	Provider Education and Training	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	02/03/2022	EE.1103	Provider Network Training	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2022	EE.1103	Provider Network Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	03/01/2023	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	10/01/2023	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	12/01/2023	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	05/01/2024	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	11/01/2024	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	01/01/2025	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	03/01/2025	EE.1103	Provider Network Training	Medi-Cal OneCare PACE
Revised	08/01/2025	EE.1103	Provider Network Training	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with CalOptima Health, or a Health Network. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within that group.
Advance Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a Member is incapacitated.
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
California Advancing and Innovating Medi-Cal (CalAIM)	A multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Direct Administrative (COHD-A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members who meet certain eligibility criteria as described in CalOptima Health Policy DD.2006 Enrollment in/Eligibility with CalOptima Health Direct.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Term	Definition
Children and Youth with Special Health Care Needs (CYSHCN)	Children and Youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CYSHCN shall comply with the requirements of 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Community Based Adult Services (CBAS)	Skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.
Critical Incident	Critical incident refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Delegated Entity	For purposes of this policy, a Delegated Entity is contracted with CalOptima Health to provide covered services to eligible CalOptima Health Members including but not limited to medical, dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Health Members.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Developmental Disability (DD)	As defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability but shall not include other handicapping conditions that are solely physical in nature.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of

Term	Definition
	health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Intellectual Disability (ID)	A condition manifested before the person reaches age twenty-two (22) and results in impairment of general intellectual functioning or adaptive behavior and significant limitations in at least three (3) or more of the following areas: communication, self-care, home living, social skills, use of community resources, self-direction, understanding and use of language, learning, mobility, capacity for independent living.
Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+)	For purposes of this policy, LGBTQIA+ is an acronym for Members that identify as lesbian, gay, bisexual, transgender and queer and/or questioning, intersex, and asexual.
Long Term Services and Supports (LTSS)	Medi-Cal: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS). OneCare: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following: 1. Community Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.

Term	Definition
	OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in a CalOptima Health program.
Network Provider	For purposes of this policy, a Provider that is contracted with CalOptima Health or a Health Network contracted with CalOptima Health for the delivery of Medi-Cal covered services.
Newly Contracted Provider	For purposes of this policy, a Provider that is newly contracted ten (10) days after active status with CalOptima Health or a Health Network contracted with CalOptima Health for the delivery of Medi-Cal covered services.
Out-of-Network Provider	A Provider that does not participate in CalOptima Health's Network.
Participant	An individual enrolled in the CalOptima Health PACE program.
Primary Care Practitioner/Physician (PCP)	Medi-Cal: A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic. OneCare: A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

Term	Definition
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Threshold Language	Medi-Cal: The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS. OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

EE.1103 Attachment A

Provider Network Training Descriptions

Attachment A: Provider Network Training Descriptions

Training Topic	Training Topic	Training Frequency
Access Standards	Includes information on the expectation of appointment, telephone access, provider availability and linguistic service standards.	Initial and Annual
Authorization Process	Includes details on how to submit authorization requests, what classifies as an urgent authorization request and how to complete an Authorization.	Initial and Annual
Behavioral Health	Includes information on CalOptima Health's delivery model, member eligibility, behavioral health clinical operations, authorization requirements, claims processing and how to locate resources on the CalOptima Health Website.	Initial and Annual
CalOptima Health/ Health Network Operations	Includes an overview of CalOptima Health's contractual relationship with Health Networks to assist contracted providers in understanding CalOptima Health and the Health Network's daily operations.	Initial and Annual
CalOptima Health Policies and Procedures	Describes where to locate CalOptima Health's Policies and Procedures on the CalOptima Health website.	Initial and Annual
CalOptima Health Programs and Initiatives	Includes an overview of CalOptima Health's programs: Medi-Cal, OneCare and PACE, as well as initiatives, including but not limited to the California Advancing and Innovating Medi-Cal (CalAIM).	Initial and Annual
Claims Submission and Payment	Includes information on what constitutes a clean claim or an acceptable Encounter. Also includes information about CalOptima Health's data clearinghouses used to submit claims and process payments. CalOptima Health is contracted with two (2) data clearinghouses (Emdeon and Office Ally) that receive and transmit EDI (Electronic Data Interchange) claims to CalOptima Health.	Initial and Annual
Clinical Practice Guidelines, Clinical Protocols, Evidence-based Practices, and Specific Levels of Quality Outcomes	Includes information about Clinical Practice and Preventative Health Guidelines, MCG Transparency Guidelines, Wellness Services, Patient Self-Management, and Shared-decision making aids. To access this information, please visit the CalOptima Health website: Clinical Practice Guidelines	Initial and Annual

Training Topic	Training Topic	Training Frequency
Community Based Adult Services (CBAS)	Includes an overview of topics related to CBAS such as provider registration (as CBAS providers rendering services to CalOptima Health members must be registered in CalOptima Health's system), eligibility verification, prior authorization, case management, claims and billing guidelines, and grievances and appeals.	Initial and Annual
Conflict Resolution	Includes details on a member's right to file a grievance with the Health Network or CalOptima Health in order to resolve any conflict/grievance and obtain resolution for instances of conflict between members and providers, members and a Health Network or members in CalOptima Health. In the instance of conflict between providers and members, providers and a Health Network or providers in CalOptima Health, providers may file a grievance with the Health Network or CalOptima Health in order to resolve any conflict/grievance and obtain resolution.	Initial and Annual
Coordination of Benefits and Covered Services	Includes an overview of the CalOptima Health programs and the services and/or benefits that are covered under each program.	Initial and Annual
Cultural Humility Training	Includes an overview how to better understand the issues and background of the Native American populations in California. To access the training, please visit the Tribal Affairs website: https://tribalaffairs.ca.gov/wp-content/uploads/sites/10/2020/11/OTA_Cultural-Humility-1.pdf	Initial and Annual
Critical Incident Reporting	Includes an overview of how to report compliance violations such as HIPAA violations, review of laws and regulations providers are mandated to follow, consequences and penalties	Initial and Annual
Customer Service & Cultural Competency Training	Includes information about : 1) language access services; 2) culturally competent care; 3) and organizational support, as well as how to contact CalOptima Health's Customer Service Department.	Initial and Annual
Data Collection and Reporting Requirements	Includes information on reporting requirements that include data collection, identifying required reports, the required data elements, monitoring submissions, timeliness of reports, the notification process of missing, incorrect, or late reports, and the Corrective Action Plan (CAP) process for reported issues of noncompliance with reporting.	Initial and Annual

Training Topic	Training Topic	Training Frequency
Dementia Care Aware Cognitive Health Assessment Training	Includes a DHCS Dementia Care Aware Cognitive Health Assessment training as well as information and resources for providers conducting cognitive assessments for members ages 65 or older. To access DHCS Dementia Care Aware Cognitive Health Assessment Training, please visit the DHCS website: https://www.dementiacareaware.org/page/show/139067	Initial and Annual
Disability Training	Includes information on prevalent chronic conditions in the population, legal obligations to comply with the American Disability Act (ADA), Section 504 of the Rehabilitation Act, and the use of culturally competent practices regardless of disability.	Initial and Annual
Diversity, Equity, and Inclusion Training	Includes information on how to improve Member outcomes by enhancing access to care, reduction of health disparities, and overall better quality of care. Training also includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.	Initial and Annual
Doula Services Training	Includes training and resources regarding services and processes related to doula services. Training includes information about services available to prenatal, perinatal, and postpartum members as well as infant care and postpartum support. Technical support in the administration of doula services is offered ensuring accountability for all service requirements contained in the contract and any associated guidance issued by the Department of Health Care Services (DHCS).	Initial and Annual
Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age	Includes an overview of EPSDT's comprehensive set of services under federal and state law including EPSDT screening, diagnostics, and treatment services and providers' responsibility in delivering medically necessary services for children and youth enrolled in Medi-Cal. To access training, please visit DHCS website: https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx	Initial and Annual
Electronic Visit Verification (EVV) Requirements and Reporting	Includes information on how to register to gain access to the state-sponsored EVV system; how to submit EVV data; and what data to submit after completing an EVV visit.	Initial and Annual
Fraud, Waste, and Abuse (FWA) and Compliance Training	Includes an overview of how the compliance program operates, how to report compliance program violations, and concepts such as laws and regulations, consequences and penalties, and correcting FWA.	Initial and Annual
Individual Health Education	Includes information and details on the California Department of Health Care Services (DHCS)	Initial and Annual

Training Topic	Training Topic	Training Frequency
Behavioral Assessment (IHEBA) Contract Requirements	requirement for primary care providers to administer a Staying Healthy Assessment (SHA) or approved alternate Individual Health Education Behavioral Assessment (IHEBA) to all Medi-Cal managed care members within one hundred twenty (120) days of enrollment with CalOptima Health and again at defined intervals.	
Long-Term Support Services (LTSS)	Includes information on a wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives.	Initial and Annual
Medi-Cal and Medicare Member Eligibility Determination and Verification Process	Includes information on how to check Member eligibility using the Provider Portal and the Interactive Voice Response (IVR) System. Providers may use these systems to verify a Member's Medi- Cal or OneCare (HMO D- SNP) eligibility.	Initial and Annual
Medical Management and Authorization Requirements	Includes information on how to obtain and submit prior authorization, what services qualify for authorization, and what cases qualify for case management.	Initial and Annual
Medical Management Delegation and Payment Responsibility	Includes information on the authorization process, what services qualify for authorization, and which entity (CalOptima Health or a delegated entity/ Health Network) may be financially responsibility for payment of services.	Initial and Annual
Member Benefits	Includes detail on where to locate resources regarding Member benefit information on the CalOptima Health website.	Initial and Annual
Member Billing Restrictions	Includes information that DHCS prohibits providers from charging Members for Medi-Cal covered services or having any recourse against the Member for Medi-Cal covered services rendered to the Member.	Initial and Annual
Member Grievance and Appeals process and requirements for Network Providers and Out-of-Network Providers	Includes an overview of the process CalOptima Health uses to address and resolve Member grievances in accordance with applicable statutory, regulatory, and contractual requirements.	Initial and Annual
Member Rights and Responsibilities	Includes information on how CalOptima Health informs its Members of their rights and responsibilities, ensures that Members' rights and responsibilities are respected and observed, and how to locate the list of Members' rights and responsibilities on the website and in Provider Manual.	Initial and Annual

Training Topic	Training Topic	Training Frequency
Model of Care	Learn the goals of CalOptima Health programs and their key components including an overall description of the Special Needs Plan (SNP) populations, care coordination, the provider network, and quality measurement and performance improvement.	Initial and Annual
Overview of Trauma-Informed Care and Historical Trauma training	Specific Historical Trauma and Trauma Informed courses include: Overview of Trauma Informed Care and Historical Trauma Informed Care, Behavioral Health Provider Series, Healthcare Provider Series Non-Provider Series, and Supervisor Series. To access the training, please visit the HIS website: https://www.ihs.gov/mentalhealth/ticmandatorytraining/	Initial and Annual
Prior Authorization Process	Includes information on how to obtain and submit prior authorization for outpatient and routine services. Training also explains how to complete an Authorization Request Form (ARF) for urgent and inpatient authorization requests.	Initial and Annual
Provider Communications	Includes details on the types of provider communications CalOptima Health offers including monthly Provider Updates, Provider Newsletters and where to locate Provider communications on the CalOptima Health website.	Initial and Annual
Provider Cultural and Linguistic Requirements	Includes information about the state and federal regulations that require CalOptima Health to make interpreter and translation services for limited English proficient (LEP) members available.	Initial and Annual
Provider Manual	Describes where to locate CalOptima Health's Provider Manual on the CalOptima Health website. The Provider Manual is a communication tool and reference guide containing basic information for providers to learn how to work with CalOptima Health.	Initial and Annual
Quality Improvement for Health Services Programs	Includes information on access standards for all CalOptima Health programs, how to report quality of care issues, HEDIS Measures and Reporting, how to complete an Initial Health Assessment (IHA) and guidance on the Facility Site Review (FSR), Medical Records Review and Physical Accessibility Review.	Initial and Annual
Seniors and People with Disabilities (SPD) Training	Includes a review of the Accommodation Checklist, an overview of the Deaf and Disabled Telecommunications Program (DDTP), disability etiquette, and learning how to communicate and interact with people who have disabilities.	Initial and Annual
Transgender, Gender Diverse or Intersex (TGI)	Includes information on the effects of historical, contemporary, and present-day exclusion,	Initial and Annual

Training Topic	Training Topic	Training Frequency
Cultural Competency Training	microaggressions, and oppression, effective communication across gender identities, trauma-informed approaches to care delivery, health inequities and family/community acceptance, perspectives from diverse constituency groups and TGI serving organizations, health plan considerations for gender-affirming care, and collaborative approaches to enhance TGI access to care.	
Subcontracted Network Certification Requirements	Includes guidance on Annual Network Certification (ANC) requirements in accordance with DHCS requirements.	Initial and Annual
Utilization Management (UM) Appeals and Provider dispute resolution process	Includes information on how to file an appeal for UM authorization decisions and how to submit a Provider Dispute Resolution (PDR) to review a contested claim.	Initial and Annual

EE.1103 Attachment B

Provider Liaison Requirements

Attachment B: Provider Liaison Requirements

Liaison Type	Roles & Responsibilities
California Children's Services (CCS) Providers	The role and responsibilities of the CalOptima Health CCS Liaison include, but are not limited to: • Serve as the CCS liaison who will serve as the primary point of contact responsible for the CCS members' care coordination • receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children
County Child Welfare	The role and responsibilities of the CalOptima Health County Child Welfare Liaison include, but are not limited to: • Having expertise in child welfare services and county behavioral health services • Ensuring appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4), and ensuring covered services are closely coordinated with other services, including social services and specialty mental health care services • Acting as a resource to the ECM providers providing services to child welfare-involved children and youth • Providing technical assistance to CalOptima Health and ECM provider staff as needed • Serving as a point of escalation for care managers if they face operational obstacles when working with County and community partners • Being sufficiently trained on county care coordination and assessment processes • Coordinating with county child welfare liaisons for other Medi-Cal managed care plans to notify them when members cross county lines and/or change managed care plans • Serving as a family advocate
Dental	The role and responsibilities of the CalOptima Health Dental Liaison include, but are not limited to: • Ensuring that dental screenings and oral health assessments are included for all members

	• Ensuring that all members are given referrals to appropriate Medi-Cal dental providers • Coordinating and providing Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional • For members less than 21 years of age, CalOptima Health must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the member's first tooth or at 12 months of age, whichever occurs first • Ensuring the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or dental anesthetists
Indian Health Care Provider (IHCP)/ Tribal	The role and responsibilities of the CalOptima Health IHCP/ Tribal Liaison include, but are not limited to: • Providing information to Indian Health Care Providers (IHCPs) regarding enrollment and disenrollment of American Indian members • Coordinating care with in- and out-of-network IHCPs for American Indian members • Ensuring access to care with in- and out-of-network IHCPs for American Indian members • Providing assistance to IHCPs and American Indian members with accessing appropriate transportation given logistical and geographical barriers unique to tribal communities • Providing case management for American Indian members that involves in- and out-of-network IHCPs • Assisting IHCPs with provider relations services, claims and payment assistance and resolution, and member services • Providing support in obtaining grievance, appeal, and State Hearing services to IHCPs in cases that impact American Indian members • Providing benefits and services navigation and coordination, such as those for Child welfare, Community-Based Adult Services (CBAS), Enhanced Care Management (ECM), Community Supports, Behavioral Health, Health Education, Home and Community Based Services, California Children's Services (CCS), etc., for IHCPs in order to provide full-spectrum services to American Indian members • Assisting internal liaisons in instances that involve IHCPs and/or American Indian members and the other liaison's respective services and program, in particular the county child welfare liaison given the observed disproportionate representation of American

	Indian youth in the child welfare system; as well as the liaisons for Long-Term Services and Supports (LTSS), Transportation, CCS, Regional Center, Dental, and In-Home Supports and Services (IHSS • Providing assistance to IHCPs regarding Medi-Cal program Provider enrollment and contracting, credentialing, and Facility Site Reviews • Attesting to the completion of the Cultural Humility training from the California Governor's Office of the Tribal Advisor, the Overview of Trauma-Informed Care and Historical Trauma training from the Indian Health Service (IHS), and other relevant trainings as they are developed and noted by DHCS • Providing assistance to the CalOptima Health's Member Services department in situations involving American Indian members • Representing CalOptima Health and providing assistance to subcontractors to address inquiries and/or instances involving American Indian members • Participating in the CalOptima Health Community Advisory Committee and other CalOptima Health committees that potentially impact American Indian members • Attending and participating in tribal consultations involving tribes within CalOptima Health's service area • Attending and participating in DHCS' Tribal and Designees of Indian Health Programs Quarterly Meeting, and other relevant meetings • Developing tribal specific outreach and educational materials • Hosting marketing events and developing marketing materials focused on tribal health as permitted • Collaborating with other Managed Care Plan (MCP) tribal liaisons to discuss best practices, lessons learned, and sharing of information and resources • Collaborating with local tribal communities on the development of regional and culturally appropriate trainings for staff • Having knowledge and consideration of Indigenous Determinants of Health when determining quality metrics and data reporting
In-home Support Services (IHSS)	The role and responsibilities of the CalOptima Health IHSS Liaison include, but are not limited to: • Coordinating with the county IHSS agency that ensures members do not receive duplicative services through ECM, Community Supports, and other services • Tracking all members receiving IHSS and continue coordinating services with the county IHSS agency for members until IHSS

	notifies CalOptima Health that IHSS is no longer needed for the member • Outreaching and coordinating with the county IHSS agency for any members identified by DHCS as receiving IHSS • Identifying members receiving, referred to, or approved for IHSS and conducting a reassessment of members' Risk Tier • Continue providing basic population health management and care coordination of all medically necessary services while members receive IHSS
Long-Term Services and Supports (LTSS)	The role and responsibilities of the CalOptima Health LTSS Liaison include, but are not limited to: • Receive training on the rules and regulations pertaining to Medi-Cal covered Long-Term Care (LTC), including payment and coverage policies; prompt claims payment requirements; provider resolutions, policies and procedures; and care management, coordination and transition policies
Regional Center (RC) Liaison	The role and responsibilities of the CalOptima Health RC Liaison include, but are not limited to: • Assisting members with Developmental Disabilities (DD) in understanding and accessing services • Acting as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10) • Referring Members with DD to a RCs for evaluation and access to non-medical services provided by the Regional Center, including, but not limited to, respite, out-of-home placement, and supportive living • Having a Memorandum of Understanding (MOU) in place as required in Exhibit A, Attachment III, Section 5.6 (MOUs with Local Government Agencies, County Programs, and Third Parties) to coordinate services for the member with RC staff to ensure the non-duplication services • Creating the individual developmental services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of medically necessary services such as medical care, Non-Specialty Mental Health Services (NSMHS), and Behavioral Health Treatment (BHT) • Maintaining policies and procedures to identify and refer eligible members to the Home and Community Based Services (HBCS) program administered by the Department of Developmental Services (DDS)

Transportation	The role and responsibilities of the CalOptima Health Transportation Liaison include, but are not limited to: • Have a direct line for providers and members to receive real-time assistance directly from CalOptima Health with unresolved transportation issues that can result in missed appointments • Triage urgent transportation calls for members and providers when they have attempted to work with the transportation broker, but the issue remains unresolved and is time sensitive

SUBJECT: Provider Education and Training **Policy #:** PR.2
DEPARTMENT: Provider Services

Effective Date: June 1, 2001
Last Revision Date: January 2022
Revised Dates: April 2023

SCOPE: This applies to All Line of Business

I. PURPOSE:

This policy outlines the initial and ongoing training and education requirements to providers regarding administrative and operational procedures and policies for compliance with IPA contractual, regulatory, and statutory requirements in providing services to members.

II. POLICY:

A. All new contracted physicians participating in the IPA shall receive an in-service regarding administrative and operational procedures and requirements for the Medi-Cal, Medicare/Medi-Medi, OneCare, Covered California Programs after the Credentialing Committee approves a new physician's credentialing.

In-services shall be completed within thirty (30) business days of physician's credentialing approval date and activation date under the IPA. An initial in-service, which includes mailing of provider manual – "Welcome Packet" will be conducted within ten (10) business days of the "Contract Effective Date".

All in-services, dates shall be documented, and at the end of the in-service/training, provider shall sign an acknowledgement notice indicating receipt of a complete provider manual and comprehension of the policies and procedures presented during the in-service. Training will include, at a minimum:

1. Health Plan programs and initiatives, including but not limited to the Whole-Child Model (WCM)/ California Children Services program and CalAIM;
2. IPA and Health Plan operations;
3. Provider Communications;
4. Members rights and responsibilities;
5. IPA policies and procedures;
6. Individual Health Education Behavioral Assessment (IHEBA) requirements;
7. Member benefits;
8. Claims submission and payment;
9. Coordination of benefits;
10. Conflict resolutions;

11. Critical Incident reporting;
12. Member Grievances and Appeals process;
13. Member billing restriction;
14. Utilization Management Appeals and Provider dispute resolution process
15. Prior authorization process;
16. Medical management and authorization requirements;
17. Customer service, cultural and linguistic requirements, cultural competency, diversity, health equity and inclusion training;
18. Community Based Adult Services;
19. Behavioral Health;
20. Medical Management delegation and payment responsibility/
21. Medi-Cal and Medicare Member eligibility determination, verification and disenrollment process;
22. Seniors and Persons with Disabilities (SPD) trainings;
23. Fraud, Waste, and Abuse and compliance training;
24. OneCare Program Overview;
25. Model of Care;
26. Access Standards;
27. Subcontract Network Certification requirements;
28. Reporting requirements;
29. Long-Term Support Services (LTSS);
30. Authorizations, claims and Member eligibility verification process for hospitals, skilled nursing facilities and ancillary providers.
31. Disability training information, including, but not limited to, the following:
    i. Chronic conditions prevalent within the population;
    ii. Awareness of personal prejudices;
    iii. Legal obligations to comply with Title II of the American Disability Act (ADA) and Section 504 of the Rehabilitation Act;
    iv. Definitions and concepts, such as communication access, alternative formats, medical equipment access, physical access, and access to programs;
    v. Types of barriers encountered by the target population;
    vi. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, wellness principles, and the recovery model;
    vii. Working with Members with mental health diagnoses, including crisis prevention and treatment;
    viii. Working with Members with substance use conditions, including diagnosis and treatment; and
    ix. HIV stigma and non-discrimination requirements;

32. Quality improvement for health services programs;
33. Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+) cultural competency training;
34. Use of culturally competent practices and access to services in a culturally competent manner for all Members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification,, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other person or groups defined in Penal Code 422.56;
35. Use of clinical protocols, evidence-based practices, and specific levels of quality outcomes;
36. Electronic Visit Verification Requirements and Reporting;
37. Health Plan New Provider Orientation Handbook if available by the health plan.

B. IPA shall provide and disseminate additional ongoing training for contracted Providers:
   1. When determined necessary;
   2. Refresher training, on an annual basis, including but not limited to:
      a. Cultural competency training;
      b. SPD trainings;
      c. Fraud, Waste, and Abuse and compliance training;
      d. Model of Care;
      e. Participation in Federal Programs; and
      f. Access Standards
   3. When conducting Provider meetings and in-services/outreach visits; and
   4. Upon request from Providers.

III. PROCEDURE:

A. Credentialing Department

1. Upon the Credentialing Committee's approval of a new provider's credentialing application, a "Welcome" letter will be sent to the physician along with a copy of the executed Agreement with the IPA and a "Physician Office Manual - Quick Reference Manual."

2. The Credentialing Department will concurrently provide a copy of the welcome letter and approval date to the Provider Services Department. The Provider Services Department will insert in the welcome letter the "Contract Effective Date".

B. Provider Services Department

1. Prior to or upon notification of the provider's approved status, the Provider Services Representative will schedule an in-service with the Provider, Office Manager, and staff within the next ten (10) business days of the effective date of the contract to review the administrative and day-to-day operational procedures and the forms required to obtain approval for and provide services to IPA members.

2. The Provider Services Representative will present the provider office with a Provider Manual containing forms, policies, procedures, and protocols through which IPA will manage and work with physician to provide services to members.

3. The Provider Services Representative will review with physician, office manager and/or office staff the processes and requirements under the following areas of operations:

    a. Eligibility & Enrollment

    b. Member Services

    c. Utilization Management

    d. Case Management

    e. Claims

    f. Provider Services & Contracting

    g. Credentialing

    h. Quality Management

4. In addition, the Provider Services Representative will provide forms that the offices are required to make available to Members, staff, and physicians:

    a. Member Grievance & Appeals Form

    b. Provider Grievance & Appeals Form

    c. IPA Complaint, Grievance & Appeals Process

    d. Health Plan Grievance & Appeal Process

    e. State Fair Hearing Process

    f. Department of Corporations Grievance & Appeal Process

    g. Initial Health Assessment Forms

5. Upon completion of the in-service, the Provider Services Representative will obtain the provider's signature on the "Check List and Acknowledgement Form", "Provider

Visit Form" and/or Health Plan Required Forms indicating completion of education. A "New Provider In-Service Evaluation" survey will also be provided to the newly contracted provider to obtain feedback regarding the quality of the training.

6. If the Provider is unable to complete the training within ten (10) business days of the "Contract Effective Date" or prior the provider's approved status the provider will not be submitted to the health plan for activation. If the Provider is unable to complete the training within thirty (30) calendar day requirement of the "Contract Effective Date" or prior to their credentialing approval, Provider Services Representative shall send the materials to the Provider's office and will document the reasons and actions taken due to non-completion of the education.

7. For non-contracted or out-of-network providers:

    a. Upon verifying and confirmation of the provider's non-contract/out-of-network provider status the Provider Services Representative will provide information to the best of their capability to the non-contract/out-of-network provider's needs as applicable and can contact internal departments to obtain information for the non-contracted provider. The Provider Services Representative will direct the non-contract/out-of-network provider to the Health Plan website as a resource (e.g., clinical protocols and evidence-based practice guidelines).

C. Reporting

1. Provider Services Department shall submit a completed Health Network Newly Contracted Provider Office Training Report or a Health Plan equivalent report to CalOptima or Health Plan on a quarterly basis, on or before the twenty-fifth (25th) day of the month following the end of the quarter or as specified by the contracted Health Plan. If the twenty-fifth (25th) day or the specified Health Plan submission date falls on a non-business day, the Provider Services Department shall submit the report no later than the next business day or based on the health plan require submission date.

IV. ATTACHMENTS:

A. Check List and Acknowledgement Form
B. Provider Visit Form
C. New Physician In-Service Evaluation
D. Health Plan required forms; if applicable
E. Welcome Letter
F. HN Newly Contracted Provider Training Report (CalOptima Reporting Template: 1_HMRPT_HN_QTYYYY_NCT)

V. REFERENCES:

None

VI. DEFINITIONS:

Term	Definition
Active Status	A Provider's, PCP's, and Practitioner's contract effective date with the IPA. Active status for a Provider, PCP and/or Practitioner added to a contracted medical group shall be the date the PCP and/or Practitioner is approved to provide services to Members within the IPA upon completion of the in-service.
California Children's Services Program (CCS)	The public health program that assures the delivery of specialties diagnostic, treatment, and therapy serviced to financially and medically eligible individuals under the age of twenty-one (21) who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR). Sections 41515.2 through 41518.9.
CalAIM Program	This Department of Health Care Services (DHCS) program is innovating and transforming the Medi-Cal delivery system by moving Medi-Cal towards a population health approach that prioritizes prevention and whole person care. The goal is to extend supports and services beyond hospitals and health care settings directly into California communities to address their physical, behavioral, developmental, dental, and long-term care needs**,** throughout their lives, from birth to a dignified end of life.
Critical Incident	Refers to any actual, or alleged, event, or situation, that creates a significant risk of substantial harm to the physical or mental health, safety, or well-being of a Member.
Health Homes Program	All the California Medicaid State Plan amendments and relevant waivers that DHCS seeks, and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community based MLTSS needed for chronic conditions.
Member	An enrollee-beneficiary of a CalOptima program.
Non-Contracted/Out-of Network Provider	Refers to a health care provider who does not have a contract/agreement with the IPA or health network.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.
Whole Child Model Program (WCM)	Is CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child rather than handle CCS Eligible Conditions separately.

A Public Agency

CalOptima

Better. Together.

Disability Awareness

2022

Learning Objectives

After completing the course, you will be able to:

- Explain the prevalence and types of disabilities within our CalOptima population.
- Identify and explain the legal requirements related to access for persons with disabilities.
- Define the basic rights of persons with disabilities.
- Identify the physical accessibility components at a provider's office that are assessed and reported by CalOptima.
- Define your responsibilities in interacting with members, visitors, patients and their companions with disabilities.
- Use appropriate terminology and proper etiquette when interacting with people with disabilities.
- Identify available CalOptima and community resources.

Course Content

- Definitions: Disability and Functional Limitations
- Americans with Disabilities Act (ADA)
- Olmstead Decision
- Barriers to Access and Care
- Access and Accommodations
- Communication Tips
- Available Resources

Note: Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

CalOptima's Commitment

- In June 2011, CalOptima initiated disability awareness and sensitivity training as required by the California Department of Health Care Services (DHCS).
- Disability awareness education continues to be required for all staff and health care providers who care for CalOptima members in any of its benefit plans.
- CalOptima is committed to ensuring that communications, services and programs are accessible to people with functional limitations, including visual, hearing, cognitive and physical disabilities.

Definitions: Impairment vs. Disability

Impairment

- Alteration of a person's health status as assessed by medical means
- Typically identified with an organ or body part
- Ranges from mild (pinky amputation) to severe (tertraplegia)
- Does not include impact on person's ability to function in society

Disability

- A physical or mental impairment that substantially limits one or more of the major life activities (mobility, cognitive, vision, speech, or hearing)
- Birth (congenital) to acquired over lifetime
- Visible or hidden

Definitions: Functional Limitations and Capabilities

Functional Limitations

- Difficulty completing basic or complex activities because of a physical, mental, or emotional restriction.
- May be due to behavioral and/or chronic health conditions.

Functional Capabilities

- Strengths of a person with a disability to perform certain activities, with or without accommodations.

Who Are People with Disabilities?

- Disabilities span a broad spectrum ranging from mild, to moderate, to severe
- Self-report surveys use the following definitions to gather statistics:

Vision	Hearing	Cognitive	Ambulatory	Self-care	Independent Living
• Blindness or serious difficulty seeing even when wearing glasses	• Deafness or serious difficulty hearing	• Serious difficulty concentrating, remembering or making decisions	• Serious difficulty walking or climbing stairs	• Difficulty bathing or dressing	• Difficulty doing errands alone, such as visiting a doctor's office or shopping

CalOptima
A Public Agency
Better. Together.

Disability Statistics

- U.S. total population of persons with a disability: **12.7%**

Vision	Hearing	Cognitive	Ambulatory	Self-care	Independent Living
2.3%	3.6%	5.2%	6.9%	2.6%	5.9%

- OC's total population of persons with a disability: **8.6%**

Vision	Hearing	Cognitive	Ambulatory	Self-care	Independent Living
1.5%	2.6%	3.4%	4.5%	2.1%	4.3%

Source: U.S. Census Bureau, 2019z' SVD 1-Year Estimates Subject Tables

CalOptima A Public Agency Better. Together.

Americans With Disabilities Act (ADA)

"No individual shall be discriminated against on the basis of disability…"

Most important legislation for disability rights	Prohibits discrimination	Fundamental Values: Equal Opportunity Integration Full participation

CalOptima
A Public Agency
Better. Together.

Americans with Disabilities Act (cont.)

- The ADA also requires:
  - Medical care providers make their services available in an accessible manner.
  - Policies, procedures and guidelines be in place regarding non-discrimination on the basis of disability.
- CalOptima is committed to providing equal access for members and their companions with disabilities.

The Rehabilitation Act of 1973

- Section 504 — Prohibits discrimination due to disabilities in programs that receive federal funding
  - "No qualified individual with a disability…shall be excluded from, denied the benefits of, or be subjected to discrimination under" any program or activity.
    - Program accessibility
    - Effective communication
    - Accessible construction and alterations
- Section 508 — Requires electronic and information technology to be accessible to people with disabilities, including employees and members of the public
  - Visual and audio outputs, optical aids
  - Accessibility-related software: JAWS (Job Access with Speech)

The Olmstead Decision

- In 1999, the Supreme Court's decision in Olmstead v. L.C.
  - Required states to provide qualified individuals with **disabilities** access to home and community-based services, rather than place them in or keep them in institutions, when:
    - Treatment professionals determine that such placement is appropriate.
    - The affected persons do not oppose such placement.
    - The state can reasonably accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities.
  - The ADA require public entities to administer their services, programs and activities in the **most integrated setting appropriate to the needs of qualified individuals with disabilities**.

Most Integrated Setting

- Key concept
  - Integrated Setting
    - Refers to a setting that: "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible..."
    - Term means services and benefits to persons with disabilities should not be separate or different from persons without disabilities unless the separate programs are necessary to ensure that the benefits and services are equally effective.
  - Least restrictive
    - Least restrictive environment is terminology for educational settings -- all other settings use the term "integrated setting".
    - A "least restrictive environment/setting possible" means members are treated in an environment and manner that respects individual worth, dignity, privacy and enhances their personal autonomy.

Knowledge Check 1

Match the term with the definition

TERM	DEFINITION
1. Disability	A. Difficulty completing basic activities
2. Impairment	B. Substantially limits life activities
3. Functional limitation	C. Strengths of a person with disability
4. Functional capacity	D. Alteration of health status by medical means

Knowledge Check 1 Answers

TERM	DEFINITION
1. **Disability**:	B. Substantially limits life activities
2. **Impairment**:	D. Alteration of health status by medical means
3. **Functional limitation**:	A. Difficulty completing basic activities
4. **Functional capacity:**	C. Strengths of a person with disability

CalOptima
A Public Agency
Better. Together.

Knowledge Check 2

Match the term with the definition

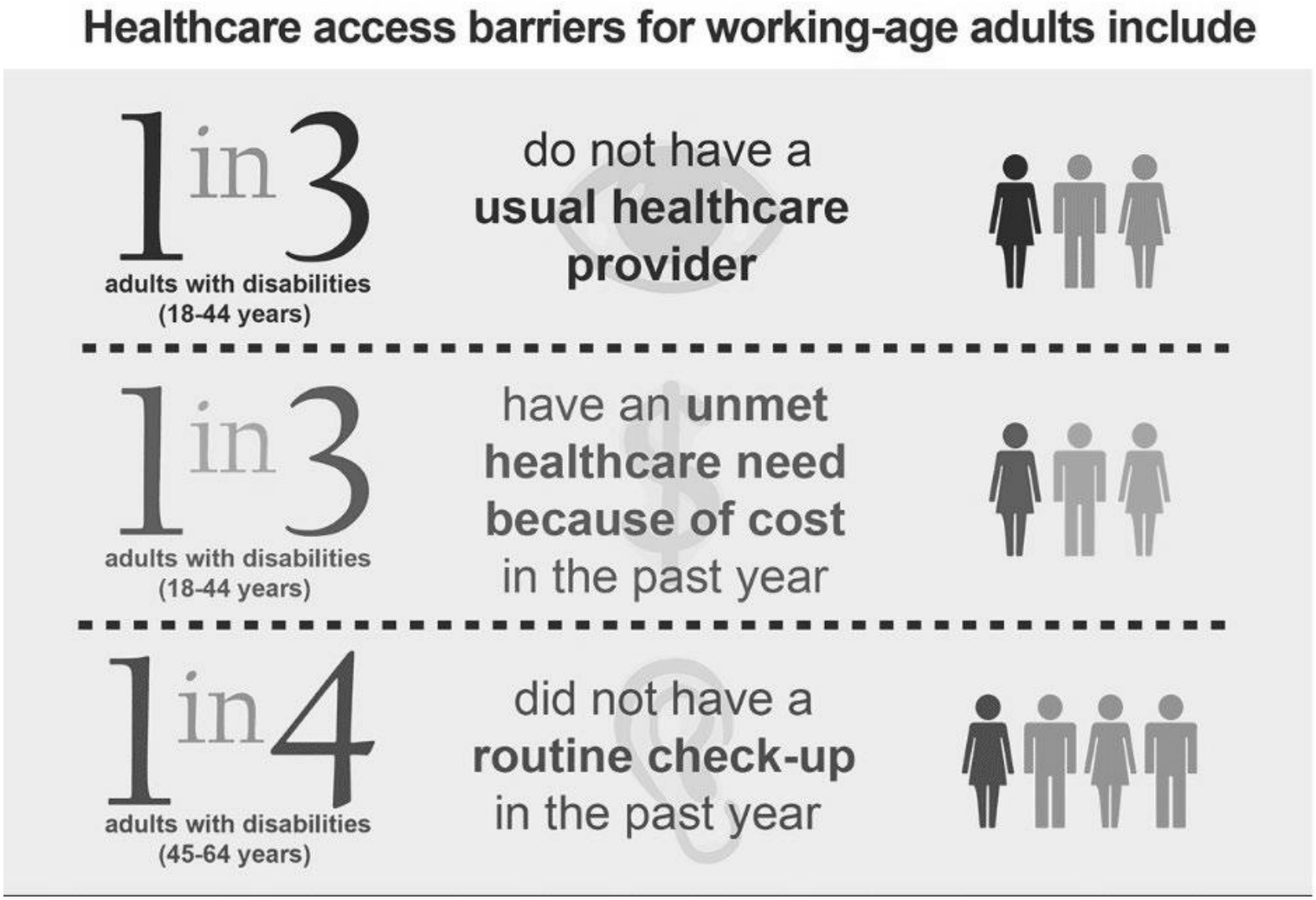
TERM	DEFINITION
5. Americans with Disabilities Act	E. Accessible technology
6. Section 508	F. Civil rights for people with disabilities
7. Section 504	G. Most integrated setting
8. Olmstead Decision	H. Program accessibility

Knowledge Check 2 Answers

TERM	DEFINITION
5. Americans with Disabilities Act:	F. Civil rights for people with disabilities
6. Section 508:	E. Accessible technology
7. Section 504:	H. Program accessibility
8. Olmstead Decision:	G. Most integrated setting

CalOptima
A Public Agency
Better. Together.

Disabilities and Healthcare Access



Source: Centers for Disease Control and Prevention. Disability Impacts All of Us, 2018. [Internet: www.cdc.gov/disabilities]

Barriers to Access and Care

- Persons with disabilities and functional limitations may encounter environmental and attitudinal barriers to care:

Physical Access	Communication Access	Program Access
Ability to get: • To • Into • Through • Onto	**Ability to:** • Understand what is being asked • Use the information given • Result in effective communication	**Participate in:** • Health education • Prevention & treatment • Community-based programs

- Most difficult barriers to overcome are **attitudes**.
  - ➢ Focus on individual's ability rather than on disability.

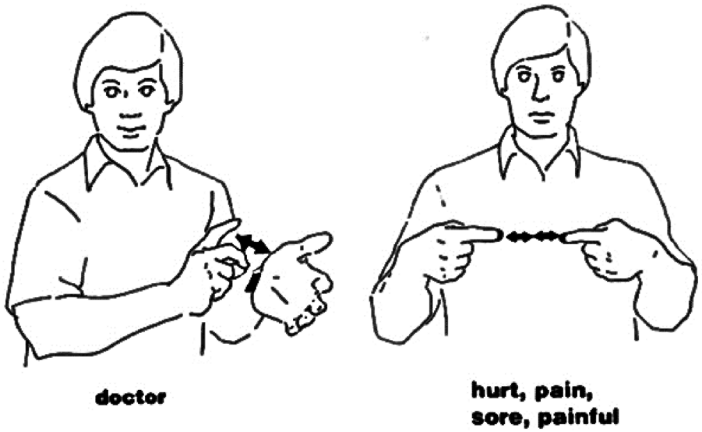
Accessibility Requirements for Providers

- Intended to meet the needs of any patient to improve program access and health outcomes.
- Two areas:

Physical access



Effective communication



CalOptima
A Public Agency
Better. Together.

Physical Access

- Facility Site Review (FSR)
  - DHCS requirement MMCD PL 12-006 requires California plans "to assess the physical accessibility of provider sites, including specialist and ancillary service providers that serve a high volume of seniors and persons with disabilities."
  - Required for all Medi-Cal contracted providers
  - FSR survey
    - CalOptima coordinates with all providers to complete the survey on a regular basis
    - Uses the DHCS Physical Accessibility Review Survey Attachment C (*PARS*)
  - Results of FSRs are available to members through the CalOptima website and the provider directory.

CalOptima's Provider Directory

- Members can identify areas of physical accessibility in an office when they search in the Provider Directory and review the office profile.

  - P = Parking
  - EB = Exterior Building
  - ET = Electronic Table
  - IB = Interior Building
  - R = Restroom
  - E = Exam Room
  - T = Exam Table/Scale



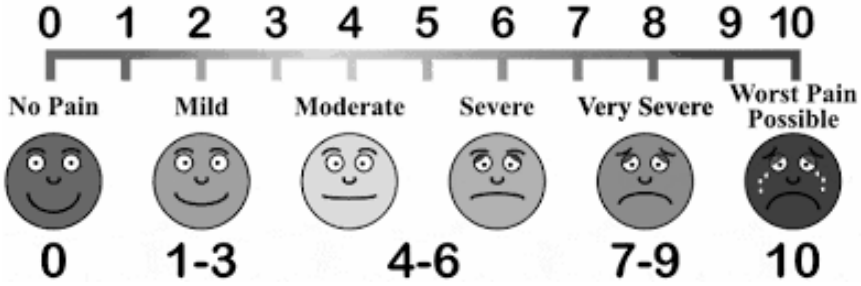
Effective Communication

- Providers and members need to get, understand and use health information to improve health outcomes.
- No cost to members for auxiliary aids and services





Large Print



CalOptima
A Public Agency
Better. Together.

Reasonable Accommodations and Access

Accommodations:

- Adjustments made to the environment or policies to enable access to services & programs

Provided for:

- Members with disabilities
- Seniors

Provided by:

- CalOptima
- Providers

Reasons for Accommodations

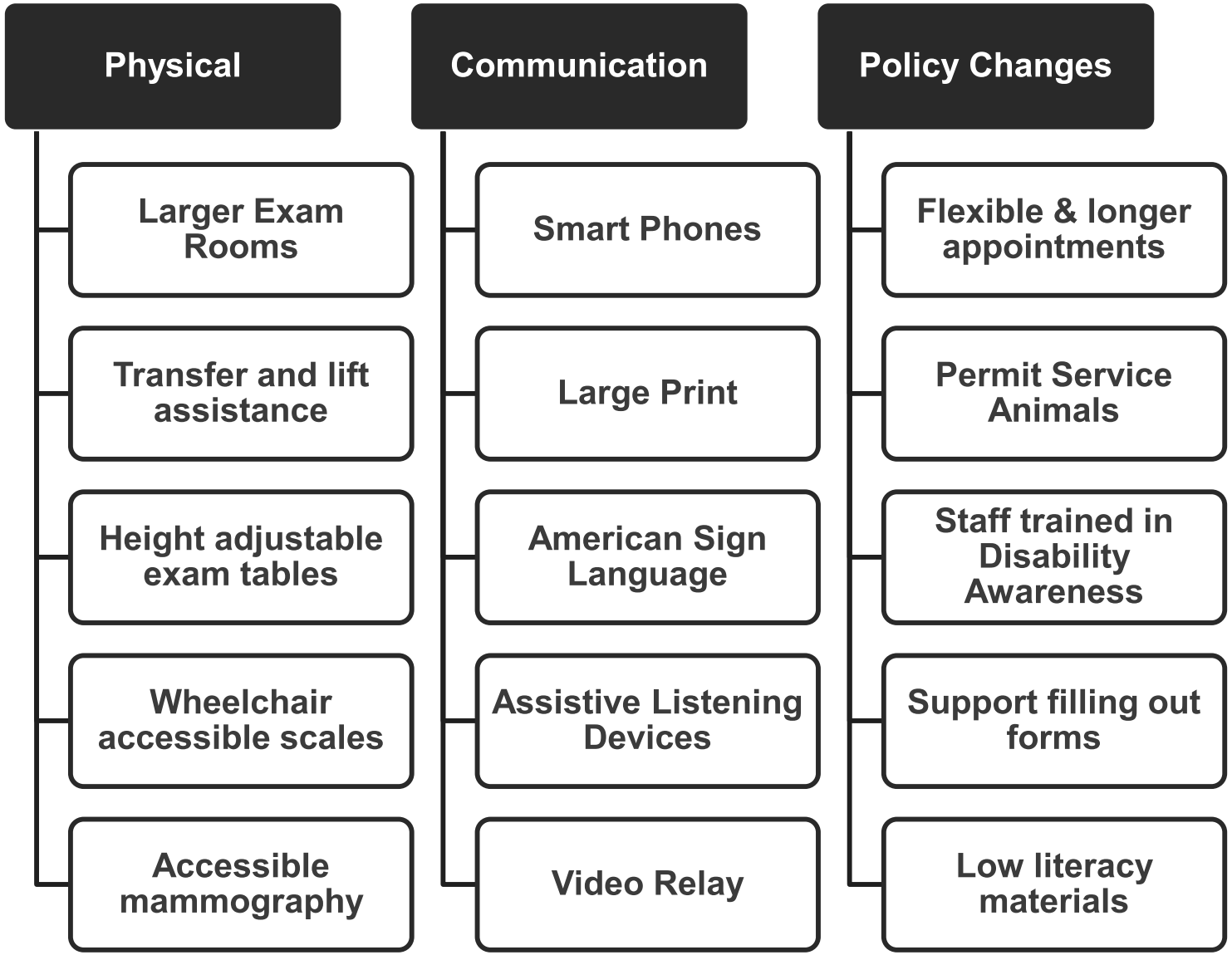
- Functional limitations may create a need for accommodations, such as:
  - Physical accessibility
  - Changes to provider office policies
  - Accessible exam or medical equipment
  - Effective communication
  - Member and health education materials in alternate formats
- Physical disabilities may be more obvious, but **unseen** mobility issues are more common.
  - For example, a member may experience an issue with physical ability to move around or walk a distance due to hip or knee problems, breathing issues, weakness, etc.
- Never assume to know the member's disability.

Identifying Accommodation Needs

- An **Accommodation Checklist** (two-page form) can be obtained from CalOptima
  - The checklist should be completed by office staff with assistance from the member, member's caregiver or authorized representative **prior** to the appointment.
  - The information from the checklist should be used to prepare appropriate accommodations.
  - Place the checklist in the member's medical or electronic record for easy access and future use.

  The checklist can be downloaded from the CalOptima website. (http://caloptima.org, Provider Training, Accommodation Checklist for Seniors and Persons with Disabilities)

Provider Accommodations



Types of Physical Accommodations











CalOptima
A Public Agency
Better. Together.

Types of Physical Accommodations (cont.)

- Put yourself in the position of a person who is sight impaired, uses a wheelchair or is hard of hearing. Then think about what you would need to access information or simply enter an office.
- Can you think of additional common types of physical accommodations? There are many barriers to access that are often overlooked by people who don't need them. These are everyday things we use, including:
  - Elevators
  - Doors
  - Doorways
  - Hallways
  - Restrooms
  - Parking lots
  - Telephones
  - Forms and documents

Types of Accommodations (cont.)

- The Deaf and Disabled Telecommunication Program (DDTP) provides access for all Californians who are deaf or disabled.
- CalOptima uses TTY(teletypewriter) to communicate with people with a hearing or speech impairment (deaf, hard-of-hearing, deaf-blind or speech disability) by calling:



Types of Accommodations (cont.)

- Auxiliary aids and services for speech impaired
  - Speech disabilities can be:
    - Developmental
    - Result of illness or injury
    - No speech
    - Difficult to understand
  - Members with speech disabilities may use:
    - Their own voice
    - Letter board
    - Pen and paper
    - Augmentative and alternative communication devices
    - Speech generating devices (SGDs) “talk” when certain letters, words, pictures, or symbols are selected
    - Speech-to-speech relay service (STS)
      - A call that uses a specially-trained communications assistant

Types of Accommodations (cont.)

Language Interpreter Services

- CalOptima has the responsibility to ensure effective communication.
  - Members cannot be required to provide their own interpreter.
  - Members' companions should only be used for interpreting for two reasons:
    - Emergencies where a qualified interpreter is not available and the safety of the individual or the public is at risk.
    - If the member requests and the companion agrees to provide interpretation in appropriate situations (this does not apply to minors).
  - Minors should not be used as interpreters.

Types of Accommodations (cont.)

Language Interpreter Services (cont.)

- **No-cost** telephone or face-to-face interpreter services
  - Available to CalOptima members (no authorization is needed).
    - Schedule face-to-face interpreter and American Sign Language (ASL) services one week in advance.
  - Health network members need to contact the member's assigned health network for language and interpreter services.

Types of Accommodations (cont.)

- Members may request health education materials in alternative formats: Braille, digital, audio or large print.
  - A health education topic in an alternative format for the member may be requested by calling CalOptima's Customer Service.
  - Members can call CalOptima's Population Health Management Library phone line (1-714-246-8895, option 2) and listen to a variety of health topics in audio format.
  - If health education information is needed right away for a member, CalOptima can be contacted to provide an oral interpreter for key information.
  - Alternative format requests to CalOptima may take up to 21 days.

Knowledge Check

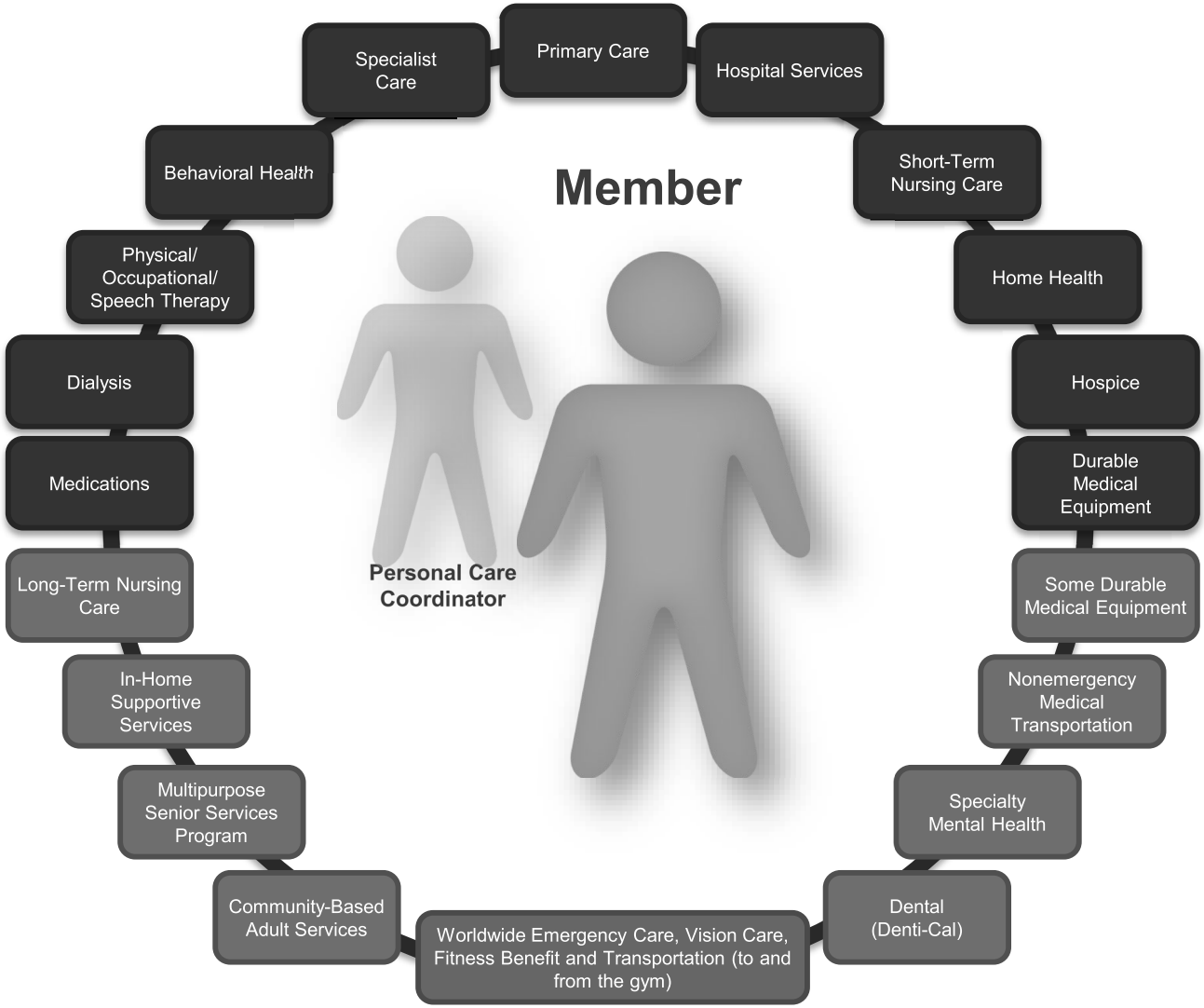
1. Language interpreters are available only if a member pays for it.
   a) True
   b) False

2. Which of the following is not an accommodation needed during a member's office visit:
   a) Physical accessibility
   b) Assistance with meals
   c) Accessible medical equipment
   d) Effective communication
   e) Health information in alternative formats
   f) All of the above

Knowledge Check Answers

1. a) False
2. b) Assistance with meals

CalOptima Model of Care



Medicare

Medi-Cal

OneCare Connect

CalOptima
A Public Agency
Better. Together.

Model of Care Promotes Access to Care

- Health Risk Assessment (HRA) identifies and assesses:

Chronic and severe health conditions	Mental health and cognitive function	Cultural and linguistic needs
Health literacy	Visual and hearing needs, preferences and limitations	Limitations to activities of daily living
Need for referrals to community services or support services	Access barriers and accommodation needs	Care management level

Model of Care Promotes Access to Care (cont.)

- An Interdisciplinary Care Team (ICT) develops an Individual Care Plan (ICP)
  - Composed of the member, primary care provider (PCP) and others key care team members as needed.
- The ICT takes the members' needs into account, including functional limitations, functional capabilities, and required accommodations, based on evidence-based practices.
- The ICT is encouraged to build a trusting relationship with members as persons with disabilities know their needs best.
- "Dignity of Risk" is a member's right to make informed choices about their health and life, even if the ICT believes these choices put the person's health or longevity at risk.

Model of Care Promotes Access to Care (cont.)

- Results in a finalized ICP that includes the member's prioritized goals and potential barriers.
  - Dynamic and person-centered plan of care for all members:
    - Includes comprehensive input from the member, member's caregiver, PCP, specialists and other providers according to member's wishes
    - Identifies member strengths, capacities and preferences
    - Provides additional care options, including transitions of care settings
    - Identifies long-term care needs and the resources available
- Members or caregivers are encouraged to contribute to the initial and re-assessment care plans.
- A member-friendly ICP is given to the member.

Recovery Model

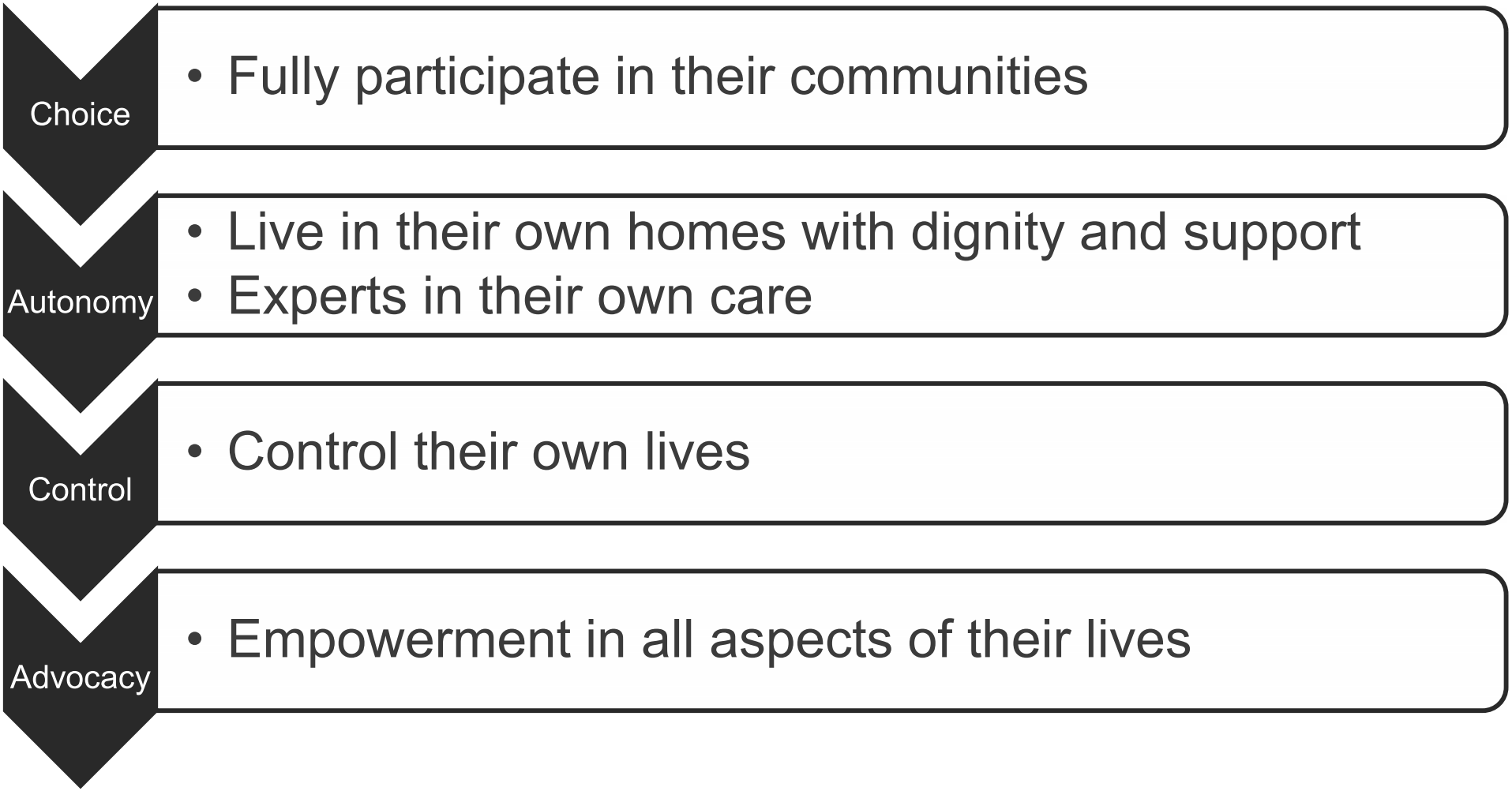
Two other important concepts in caring for the member:

1. Recovery Model
2. Independent Living

Recovery Model:

- A holistic approach widely accepted and used in behavioral health that focuses on personal strength and empowerment to make changes.
- Member's care team will consider a member's medical, psychosocial and behavioral needs when developing a plan of care.

Independent Living



Source: National Council on Independent Living. (2015)

Knowledge Check

1. When an Individual Care Plan (ICP) is developed for a member it must take the members' needs into account, including required accommodations.
   a) True
   b) False

2. CalOptima strives to ensure that members with disabilities get accommodations to meet their:
   a) Physical needs
   b) Health care needs
   c) Psychosocial needs
   d) Language needs
   e) All of the above

Knowledge Check (cont.)

3. Resources to assist with language interpreter services, health education materials in alternative formats and a copy of the Accommodations Checklist can be found on:
   a) CalOptima's website at www.caloptima.org
   b) At the library
   c) At the local Social Services office

Knowledge Check Answers

1. a) True
2. e) All of the above
3. a) CalOptima's website at www.caloptima.org

Communication Tips

- When talking about a disability or with a person with disabilities, focus on the person, not the disability, avoid negative language and use people-first language

Use People-First Language			
Person with a disability	Person who is deaf	Person who uses a wheelchair	Person with an intellectual disability

Avoid Negative Language:
Handicapped person, blind person, wheelchair-bound or mentally retarded

Communication Tips (cont.)

If you have trouble communicating:	
Ask the member how he or she wants to communicate	Speak slowly, clearly and patiently, and give time to respond

Don't:

Assume — which also includes not assuming someone from another culture understands American Sign Language.

Rush or ask the member to hurry.

Communication Tips (cont.)

When assisting a member with limited mobility:				
Sit down	Relax, speak directly and be attentive	Ask before you attempt to help	Ask how assistive devices and equipment work if you don't know	Move furniture or objects

Don't:

Stand; speak through a caregiver or companion or treat the person as invisible; start pushing someone's wheelchair unless asked; touch or move a person's wheelchair, cane, crutches or walker without consent.

Communication Tips (cont.)

- Members who are blind or have low vision may use:
  - A white cane
  - A service dog
  - A sighted guide (a technique that enables a person who is blind to use a person with sight as a guide)

These members may or may not need assistance			
Identify yourself	Ask before you attempt to help	Give specific directions	Use sighted guide technique, if asked

Don't:

Shout; move away without excusing yourself first; pet or distract a guide dog; move someone's cane without asking — if you move it, tell them where it is.

Communication Tips (cont.)

Members who are deaf or have hearing loss may need consideration:				
Speak clearly and slowly, use more facial expressions and body language	Offer pen and paper	Ask if a sign language interpreter is needed	Make eye contact and speak directly to the person, not the interpreter	Make sure written materials are available

Don't:

Shout; assume the member will not speak; assume an interpreter is needed or wanted; look down, read or mumble.

Communication Tips (cont.)

Members with speech disabilities may need consideration:			
Allow them to say what they want to say	Be polite	Ask them to repeat or rephrase, or offer a pen and paper	Be considerate

Don't:
Finish their sentences or cut them off; mimic or mock their speech; assume you know what they are saying; or be patronizing.

Communication Tips (cont.)

Members with cognitive disabilities may need consideration:			
Listen to ensure understanding	Change words you use	Keep it simple. Break ideas into small pieces that can be more easily remembered	Be considerate

Don't:
Get frustrated; use complicated language or technical terms; speak for long periods of time; or be patronizing.

Communication Tips (cont.)

Members with learning disabilities may need consideration:			
Put instructions and important information in writing if member has short-term memory issues	Use hands-on training	Provide a quiet environment	Be considerate

Don't:

Assume member will remember; use complicated language or technical terms; enable distractions for you and the member; or be patronizing.

CalOptima
A Public Agency
Better. Together.

Communication Tips (cont.)

Members with mental health and/or substance abuse conditions may need consideration:					
Know how to get help in the event of a crisis, remain calm and offer support	Keep stress levels to a minimum	Change words you use	Ask what environment they are most comfortable in	Listen to ensure understanding	Be patient

Don't:

Ignore what members say; get frustrated; use complicated language or technical terms; speak for long periods of time; assume member will remember; or be patronizing.

Available Resources

- To schedule a language interpreter or American Sign Language interpreter:
  - Obtain instructions from the CalOptima website. (http://caloptima.org, Provider Training, Seniors and Persons with Disabilities, How to Access Interpreter Services)
  - Contact the member's assigned health network, if the member is in a health network.
  - Call CalOptima's CalOptima Customer Service department
    - 24 hours a day, 7 days a week.
    - Toll-Free: **888-587-8088**
    - TTY: **711** or **800-735-2929**
- To request printed member or health education materials in alternate formats, contact CalOptima's Customer Service.

Available Resources (cont.)

- Information and resources are available on CalOptima's website at www.caloptima.org
- CalOptima offers resources for providers and staff:
  - Seniors and Persons with Disabilities Training and Resources
  - Behavioral Health Resources
- CalOptima's Provider Resource Line at **714-246-8600**
- Aging and Disability Resource Connection of Orange County (ADRCOC) at **800-510-2020** or visit www.adrcoc.org
- The Dayle McIntosh Center for the Disabled

Available Resources (cont.)

- Centers for Disease Control and Prevention, Disability and Health [www.cdc.gov/disabilities]
- Deaf and Disabled Telecommunications Program (DDTP), 1-800-806-1191 [http://ddtp.cpuc.ca.gov]
- California Telephone Access Program [www.youtube.com/watch?v=9j3lwGUvS0c]
- California Relay Service (CRS) [http://ddtp.cpuc.ca.gov/default1.aspx?id=1482]
- Speech-to-Speech Training Video https://www.youtube.com/watch?v=PQvUHMatTKc

Knowledge Check

1. An example of people-first language is:
   a) Handicapped man
   b) Nut case
   c) Person who uses a wheelchair

2. When communicating with members with disabilities, you should:
   a) Be patient and listen carefully
   b) Ask the member to repeat themselves, if needed
   c) Use Speech-to-Speech Relay, if necessary
   d) Call CalOptima for help right away
   e) a, b and c
   f) a, b, c and d

Knowledge Check (cont.)

3. A member may request CalOptima materials or health education materials in alternate formats (e.g., language of choice, Braille, audio tape, etc.) by contacting:
   a) Any Orange County community agency
   b) CalOptima Customer Service
   c) Local adult education program
   d) Materials in alternative formats are not available to CalOptima members

4. A cognitive disability refers to a person's ability to plan, comprehend, and reason or apply social and practical skills in everyday life. When speaking to a person with this type of disability, using complicated language or technical terms is the best way to help them understand.
   a) True
   b) False

Knowledge Check (cont.)

5. Case Study

Debbie, age 30, has moderate-severe quadriplegia cerebral palsy, uses a power wheelchair and speech generating device, and needs personal hygiene assistance. She has a new PCP and is scheduled for her first appointment. However, her caregiver will not be able to accompany her to the appointment.

What are some accommodations the provider office staff should consider for Debbie's appointment?

a) Complete the Accommodations Checklist for Seniors and Persons with Disabilities with Debbie over the phone to identify her accommodation needs prior to her appointment.
b) Transfer and lift assistance
c) Wheelchair accessible scale
d) Longer appointment time
e) Assistance with paperwork
f) All of the above

Knowledge Check Answers

1. c) Person who uses a wheelchair
2. e) a, b and c
3. b) CalOptima Customer Service
4. b) False
5. f) All of the above

Authorities

- Title 29, United States Code, Section 794 (section 504 of The Rehabilitation Act of 1973)
- Americans Disabilities Act of 1990
- DHCS Facility Site Review (FSR), Physical Accessibility Review Survey (Attachment C – “29 elements”)
- Cal MediConnect CMS/DHCS/CalOptima 3-way Contract
- Department of Health Care Services (DHCS)
- Welfare and Institutions Code, Section 14182 (b) (5)

References

- CalOptima Policy AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training
- CalOptima Policy CMC.1003: OneCare Connect Staff Education and Training
- CalOptima Policy CMC.4002: Cultural & Linguistic Services
- CalOptima Policy EE.1103: Provider Education and Training
- CalOptima Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment Policy
- CalOptima Policy GG.1324: Seniors and Persons with Disabilities Comprehensive Case Management
- CalOptima Policy GG.1608: Full Scope Site Reviews
- CalOptima Policy MA.1001: Glossary of Terms
- CalOptima Policy MA.7007: Access & Availability Standards
- CalOptima Model of Care


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

Orange County Physicians IPA Medical Group, Inc. dba
Noble Community Medical Associates Mid-Orange County (Noble Mid-OC)
DIRECT ACCESS REFERRAL AUTHORIZATION

c/o HEALTHSMART MSO, INC. P.O. BOX 6300, Cypress, CA 90630-0063
Phone: (714) 947-8600 UM Fax: (714) 947-8700

WARNING: This transmission contains protected health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law. This message is intended as requested for authorization of services. The following is confidential and considered privileged by law. If the reader of this transmission is not the intended recipient or a designated party of behalf of, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify the UM Department at (714) 947-8600 and shred this information.

MEMBER MUST BE ELIGIBLE ON SERVICE DATE FOR THIS DIRECT AUTHORIZATION TO REMAIN VALID
Eligibility verification required prior to service.

PRIMARY CARE PHYSICIAN	SPECIALIST
Name: Address: Phone #: Fax#:	Name: Address: Phone #: Fax#:

PATIENT INFORMATION

Patient Name: _____ Phone #: _____
LAST NAME, FIRST NAME MI

Address: _____ Health Plan: _____

_____ Member ID# _____

Date of Birth: _____/ _____/_____ Male / Female Date Requested: _____

Interpreting Assistance: Y or N Language: _____

PROCEDURES/SERVICES [CIRCLE]	CONDITIONS FOR APPROVAL	[Check here]
X-Ray (Ages 2 and above): Excluding MRIs, Ultrasounds & CT Scans	UMI—6131 Orangethorpe Ave Suite 130 Buena Park Tel: (714)522-2077 Fax (714-522-2474 UMI- 1801 W. Romneya Dr. Suite 104 Anaheim Tel (714) 678-4000 Fax (714-678-4022 UMI- 12665 Garden Grove Blvd Ste 103; Garden Grove Tel (714) 620-8200 Fax (714) 620-8211 UMI- 16161 Gothard St. Suite C Huntington Beach Tel (714) 500- 6600 Fax (714) 500-4099 UMI- 11160 Warner Ave. Suite 105; Fountain Valley Tel (714) 619-7500 Fax (714) 619-7599 UMI – 15825 Laguna Canyon Rd. Suite 101 Irvine Tel (949) 777-9000 Fax: (949) 777-9007	
Mammogram: Screening/Diagnostic	UMI locations listed above (excluding Irvine Location)	
Flu Shot	For Seniors 65+ / Mbrs with chronic lung /cardiac disorders; Pediatric members meeting CDC Recommendations	
Well Woman/Family Planning	Per AB 12, No prior Authorization required	
Family Planning - TAB	No prior authorization required, unless hospitalization required for treatment	
Total Obstetrical Care	**LMP**: **EDC**: **PNR sent to CalOptima**: Y / N	
Annual Retinal Exam	For members with Diabetes 99203 or 99213	
Orthopedic Care for Fracture	Level 3 Consult x 1 plus 2 follow-ups, casting and xrays.	
Pediatric Asthma Care	Family Pharmacy Tel: (562) 591-4417 Fax: (562) 591-0416 Circle: Nebulizer w/mask & tubing / Spacer / Peak Flow Meter	
Laboratory services must be referred to: **Laboratory Corporation of America** – 1(800) 859-6046 effect 10/01/12		

MEDICAL INFORMATION

Service Requested: _____ ICD-10 Code(s): _____

Planned Date of Service: _____ # of Visits: _____ Duration: _____
(For services/procedures)

History: (Including Diagnosis, symptoms, findings & previous treatment) Notes Attached: YES NO

Referring Physicians Signature: _____ Date: _____

NOTE TO PCP: This form must be faxed to HealthSmart the same day as given to the member.
NOTE TO CONTRACTED PROVIDER: This is a direct referral approval for services as requested above. You will be sent a letter confirming this approval with an authorization tracking number for your billing purposes. If any other service is needed that is not listed on this authorization, please contact the member's Primary Care Physician PRIOR to treatment. Effective 1/15/2019

THIS TRANSMISSION CONTAINS HEALTH INFORMATION THAT YOU ARE REQUIRED BY LAW TO MAINTAIN IN A SECURE AND CONFIDENTIAL MANNER. RE-DISCLOSURE IS PROHIBITED. FAILURE TO MAINTAIN CONFIDENTIALITY OR RE-DISCLOSURE WITHOUT AUTHORIZATION COULD RESULT IN PENALTIES AS DESCRIBED IN STATE AND FEDERAL LAW.

Orange County Physicians IPA Medical Group, Inc. dba

Noble Community Medical Associates, Inc. of Mid-Orange County (Noble Mid-OC)
C/O HealthSmart Management Services Organization, Inc.
P.O Box 6300 Cypress, CA 90630-0063
Tel: (888) 880-8811 or (714) 947-8600 Fax: (714) 947-8700
***** ALL Radiology to go to United Medical Imaging (UMI) *****

DATE:_____ADMISSION/SERVICES DATE:_____HEALTH PLAN:_____

☐ NON-URGENT

☐ RETROSPECTIVE

Emergency - Call Stat Hotline (800) 375-4692

☐ URGENT (Defined as "A situation where the time frame of the standard decision making process could **seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function**.")

PATIENT'S NAME:_____DATE OF BIRTH:_____

ADDRESS:_____
STREET CITY STATE ZIP

PATIENT'S TEL: (___)_____MEMBER #:_____

PRIMARY INSURED'S NAME:_____SOCIAL SECURITY #:_____

PCP:_____	REFERRING M.D.:_____	REQUESTED SPECIALIST:_____
ADDRESS:_____	ADDRESS:_____	ADDRESS:_____
PHONE # (___)_____	PHONE #: (___)_____	PHONE #:(___)_____
FAX #: (___)_____	FAX #: (___)_____	FAX #: (___)_____

☐CONSULT ☐FOLLOW-UP VISIT#:_____ ☐ TOTAL OB CARE:_____
EDC/LMP

☐PT/OT/ST VISIT(S) # FREQUENCY:_____ ☐PROCEDURE/SURGERY:_____

DIAGNOSIS/ICD-10:_____ _____ _____ _____ _____ _____

REQUESTED PROCEDURE(S) CPT CODE(S): **(Must be included)**

(1)_____ (1)_____

(2)_____ (2)_____

(3)_____ (3)_____

MEDICAL NECESSITY INFORMATION:_____

_____ _____
REFERRING PHYSICIAN SIGNATURE

ATTACH DOCUMENTATION TO FACILITATE DETERMINATION OF REFERRAL

UTILIZATION MANAGMENET COMMITTEE DECISION

UM COMMITTEE DECISION: ☐APPROVED ☐DENIED ☐DEFERRED ☐MODIFIED

COMMENTS:_____

UM REPRESENTATTIVE SIGNATURE:_____DATE:_____

ALWAYS VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICE. PLEASE SUBMIT CLAIMS TO:
P.O. BOX 6301, CYPRESS, CA 90630-0018

WARNING: THIS MESSAGE IS INTENDED ONLY FOR THE PERSON LISTED ABOVE. THE ATTCHED INFORMATION IS CONFIDENTIAL AND CONSIDERED PRIVILEGED BY LAW. IF THE READER OF THIS FAX IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS INFORMATION IS STRICTLY PROHIBITED. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE NOTIFY US AND SHRED THIS INFORMATION. THANK YOU FOR YOUR COOPERATION.

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid-Orange County
c/o HealthSmart Management Services Organization, Inc.

Mailing: P.O. Box 6300, Cypress, CA 90630-0063
Phone (714) 947-8600; Fax (714) 947-8702

August 2, 2023

Dear OCPIPA/Noble Mid Orange County Providers:

Attached is your updated Specialty Physician Roster.

1. If you are a Primary Care Physician, please refer only to the contracted Specialist listed on this Roster. Please refer to this roster to ensure the Specialist you would like to refer to is a contracted provider.

2. **Please note:** **Please direct your patient's care to the following:**

   (1) Fountain Valley Regional Hospital & Medical Center
   17100 Euclid St., Fountain Valley, CA 92708
   Tel: (714) 966-7200

3. **HOSPITALISTS:** Please use the following contracted Hospitalists:

Pediatric Ages 0-17.99 & Neonatology	**Pediatric & Neonatology Med Grp of Orange County, Inc.** Jacob Sweidan, M.D. Soe Naing, M.D. Jagdish S. Bhatt, M.D. Suha Newhide, M.D. Purificacion Tumbaga, M.D. **CCS Providers**	Tel: (714) 537-6595	South Coast Global Medical Center Garden Grove Hospital & Medical Center Fountain Valley Regional Hosp Med Center UCI Medical Center Anaheim Global Medical Center Orange County Global Medical Center St. Joseph Hospital-Orange Hoag Memorial Hospital Presbyterian Children's Hospital of Orange County St. Mary Medical Center (LB) Dignity Health California Hospital Medical Center Miller Children's and Women's Hospital Orange Coast Global Medical Center
16 and Older	Navneet Kaur Singh, D.O. Pulmonary Disease/Critical Care Medicine CCS: Provider: Yes	Tel: (949) 873-5537	Kindred Hospital – Westminster Hoag Memorial Hospital Presbyterian St. Mary Medical Center
Adult 18 yrs & older	**Pathways Medical Group, Inc**. Asaad Hakim, M.D. Joshua P. Peloquin, M.D.	**24 Hour Exchange:** **(714) 379-6091** Dr. Hakim cell: (714) 467-5059	South Coast Global Medical Center Garden Grove Hospital & Medical Center
	Raj Menon. M.D.	Cell: (714) 200-3031 Pager: (714) 239-0345 Exchange: (714) 556-6666	Fountain Valley Regional Hosp & Med Ctr
Adult 18 yrs & older	Harishchandra Patel, M.D.	Tel: (714) 527-7000 Fax: (714) 952-0336	St. Jude Medical Center
Adult	Juan M. Polanco, M.D. Internal Medicine	Tel: (562) 533-0584	St. Mary Medical Center Long Beach Memorial Medical Center
All Ages	Samir J. Azzam, M.D.	Tel: (714) 726-2100	Anaheim Global Medical Center Orange County Global Medical Center Anaheim Regional Medical Center
All Ages	Hassan Ragab, M.D.	Cell: (714) 349-9300 Exchange: (714) 776-2100	Anaheim Regional Medical Center
18 yrs & older	Alexander Sweidan, M.D. CCS: Provider: Yes	Cell: (310) 729-5303	St. Mary's Medical Center Hoag Memorial Hospital UCI Medical Center
Adult Ages 15 and Up	Prohealth Partners Hospitalist Babak Gachpaz, M.D. CCS: Provider: Yes	(818) 472-3340 (562) 462-6388 Pager	St. Mary Medical Center
Adult Ages 15 and Up	Prohealth Partners - Hospitalist Wisam Khader, D.O. CCS Provider: YES	(304) 654-5563 (562) 462-6798 Pager	St. Mary Medical Center
Adult Ages 15 and Up	ProHealth Partners Hospitalist Rasam Hosseinian CCS Provider: NO	(949) 484-3283 (562) 462-8786 Pager	St. Mary Medical Center
Adult Ages 15 and Up	ProHealth Partners Hospitalist Iris Partovi, M.D. CCS Provider: YES	(408) 250-3821 (562) 462-8679 Pager	St. Mary Medical Center
Adult Ages 15 and Up	ProHealth Partners Hospitalist Fazeel Shah, M.D. CCS Provider: YES	(217) 663-8237 (562) 462-5864 Pager	St. Mary Medical Center

Adult Ages 15 and Up	ProHealth Partners Hospitalist Matthew Hakimi, M.D. CCS Provider: YES	(310) 428-7343 Use Per Diem	St. Mary Medical Center
Adult Ages 15 and Up	ProHealth Partner Hospitalist Joea Rajveer, D.O. CCS Provider: YES	(559) 473-5083 (562) 462-8905 Pager	St. Mary Medical Center
Adult Ages 15 and Up	ProHealth Partner Hospitalist Ravi Solanki CCS Provider: YES	(661) 428-5283 (562) 462-8260 Pager	St. Mary Medical Center
Adult Ages 15 and Up	ProHealth Partner Hospitalist Seiya Tokunaga, D.O. CCS Provider: YES	(818) 424-5283 Use Per Diem	St. Mary Medical Center
Adult Ages 18 and Up	ProHealth Partner Hospitalist Mamak Estesam, M.D. CCS Provider: YES	(408) 881-4177 Cell	St. Mary Medical Center
Adult Ages 18 and Up	ProHealth Partner Hospitalist Sanam Pournaki, M.D. CCS Provider: YES	(347) 419-1864	St. Mary Medical Center
Adults	Aaron Jeng, M.D Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adults	Cornelia Odell, M.D. Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adults	Jeff Shapiro, M.D Southern California Hospitalist Network	(800) 940-2243 Answering Service (818) 429-2472 Cell	Huntington Memorial Hospital
Adults	Kasha Twardowska, M.D Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adults	Luisa Schulman, N.P Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adult	Maritess Aranas, M.D Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adult	Raffi Hodikian, M.D Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adult	Robert Siew, M.D Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adult	Huang-Wei Lee, M.D Southern California Hospitalist Network	(800) 940-2243 Answering Service	Huntington Memorial Hospital
Adult	Daniel Hilton, M.D.	Cell: (310) 612-4404	Fountain Valley Regional Hospital
Adult	Joseph Nassir, M.D.	Cell: (714) 642-4760	Fountain Valley Regional Hospital Orange Coast Memorial Medical Center
All Ages	Hitesh C. Patel, M.D.	Cell: (714) 272-4095 Exchange: (714) 891-4549	Orange Coast Memorial Medical Center

4. **Urgent Care Center**

StrongKids Medical Group, Inc. **AFTER HOUR URGENT CARE**
2222 S. Main St. **PEDS & ADULTS**
Santa Ana, CA 92707
Tel: (714) 436-9999 Hours: M-F 5pm-6pm; Sat 9am-6pm (excluding major holidays)

StrongKids Medical Group, Inc. **AFTER HOUR URGENT CARE**
12665 Garden Grove Blvd., Suite 713 **PEDS (up to 18 years old only)**
Garden Grove, CA 92843
Tel: (714) 537-6595 Hours: M-F 5pm-7pm; Sat 9am-1pm

Advance Urgent Care Medical Group– Dara Saghafi, M.D.
1401 W. First St., Suite 101 **CCS: No**
Santa Ana, CA 92703 **CHDP: No**
Tel: (714) 542-9700 Hours: M-F 8am-10pm; Sat 8am-7pm; Sun 9am-6pm **CPSP: No**

Dusk to Dawn Urgent Care – Eugene Allen, D.O.
3356 W. Ball Rd., Suite 120
Anaheim, CA 92804
Tel: (714) 828-2273 Hours: M-F 9am-9pm

Sunrise Multispecialist Medical Center – William H. Nuesse, M.D. **CCS: No**
867 S. Tustin St. **CHDP: No**
Orange, CA 92866 **CPSP: No**
Tel: (714) 771-1420 Hours: M-F 7am-10pm; Sat 9am-5pm

AME Medical Group, Inc.
11938 Paramount Blvd. Tel: (562) 923-6060
Downey, CA 90242 Fax: (562) 923-6601
Hours: M-F 9am-9pm; Sat 10am-5pm; Sun 10am-3pm

2nd Address:
8500 Florence Ave., Suite 101 Tel: (562) 202-5020
Downey, CA 90240 Fax: (562) 923-6601
Hours: M-F 9am-9pm, Sat 10am-5pm, Sun 10am-3pm

3rd Address:
3300 E. South St., Suite 209 Tel: (562) 444-0022
Long Beach, CA 90805 Fax: (562) 444-0022
Hours: 9am-7pm, Sat 10am-3pm

4th Address:
12472 Washington Blvd. Tel: (714) 451-2230
Whittier, CA 90602 Fax: (714) 451-4830
Hours: M-F 9am-8pm, Sat 10am-3pm

5th Address:
3625 Martin Luther King Jr. Blvd., Ste 8 Tel: (323) 585-8876
Lynwood, CA 90262 Fax: (562) 923-6601
Hours: M-F 10am-6pm, Sat 10am-3pm

5. Please fax all Referral Authorization Requests to Fax (800) 934-9700

6. Please send all Claims and Encounter Data to:
Mail: P.O. Box 6301, Cypress, CA 90630-0018
Fax: (714) 947-8275 - Attn: Claims or Encounter Data

7. If you have eligibility questions, please call:

For CalOptima Members, call OCPIPA/Noble Mid-OC: (Medi-Cal)	(888) 880-8811
CalOptima Member Services:	(714) 246-8600
Anthem Blue Cross Member Services:	(800) 407-4627
Astiva Health	(866) 688-9021
Brand New Day/Bright Health	(866) 255-4795
Central Health Plan/Bright Health	(866) 314-2427
WellCare Health Plan/Centene – Formerly: Easy Choice Health Plan Member Services:	(866) 999-3945
Health Net/Centene Medicare:	(800) 675-6110
HealthSmart Management Office:	(714) 947-8600
HealthSmart Management Office:	(714) 947-8600

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid-Orange County
c/o HealthSmart Management Services Organization, Inc.

P.O. Box 6300, Cypress, CA 90630-0063
(888) 880-8811; (714) 947-8600; UM Fax (800) 934-9700

Primary Care Physicians: 8/2/2023

Kyu D. Ahn, M.D. — **Internal Medicine** — **(12 years and older)**
12555 Garden Grove Blvd., Suite 505
Garden Grove, CA 92843
Tel: (714) 539-6100
Fax: (714) 539-6574

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M, W, F, Sat 9am-1pm; T, Th 2pm-6pm
Provider Languages: Korean
Staff Languages: Korean
Hospital Privileges: Garden Grove Hospital & Medical Center

Chung T. Bui, M.D. — **General Practice** — **(CLOSED PANEL – CAL OPTIMA)**
10301 Bolsa Ave., Suite 102
Westminster, CA 92683
Tel: (714) 531-2203
Fax: (714) 531-2498

(All Ages)

CCS: No
CHDP: Yes
CPSP: No

Board Certified: N
Hours: M, T, W, F 10am-6pm; Sat 10am-2pm
Provider Languages: Vietnamese, French, Spanish
Staff Languages: Vietnamese
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center

Uyen D. Bui, M.D. — **Pediatrics** — **(0-21 years)**
K.B. Pediatrics, Inc.
1005 S. Harbor Blvd.
Santa Ana, CA 92704
Tel: (714) 775-5537
Fax: (714) 775-5538

CCS: No
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm; Sat 10am-1pm
Provider Languages: Spanish, Vietnamese
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center

Hao K. Cao, M.D. — **Family Medicine** — **(All Ages)**
Central City Community Health Center
12116 Beach Blvd.
Stanton, CA 90680
Tel: (714) 898-2222
Fax: (714) 894-9865

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm,
Staff Languages: Spanish, Vietnamese
Hospital Privileges: Admit Panel

2nd Address: 2237 W. Ball Rd.
Anaheim, CA 92804
Hours: M-F 9am-6pm
Staff Languages: Spanish, Vietnamese
Tel: (714) 490-2750
Fax: (714) 490-2757

Antonio Carbayo, M.D. — **Family Medicine** — **(All Ages)**
Full Health Universal Medical Clinic
1911 Broadway St.
Santa Ana, CA 92706
Tel: (714) 667-6900
Fax: (714) 667-6116

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M,T,Th,F 9am-5pm; Sat 9am-1pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: South Coast Global Medical Center, Orange County Global Medical Center

Joseph Carella, MD | **Pediatrics** | **(0-21 years)**
Clinica Medica Familiar de Santa Ana
517 N. Main St., Suite 1000 | Tel: (714) 647-0401 | **CCS: Yes**
Santa Ana, CA 92701 | Fax: (714) 647-9465 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-7pm; Sat 9am-5pm; Sun 9am-1pm
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Edward E. Chai, M.D. | **Pediatrics** | **(0-21 years)**
Bristol McFadden Medical Group
1212 S. Bristol St., Suite 16 | Tel: (714) 966-0646 | **CCS: Yes**
Santa Ana, CA 92704 | Fax: (714) 966-2438 | **CHDP: Yes**
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5:30pm
Provider Languages: Thai, Spanish
Staff Languages: Spanish, Thai
Hospital Privileges: Admit Panel, Orange County Global Medical Center, Children's Hospital of Orange County

Kasin Chai, M.D. | **Pediatrics** | **(0-21 years)**
Bristol McFadden Medical Group
1212 S. Bristol St., Suite 16 | Tel: (714) 966-0646 | **CCS: No**
Santa Ana, CA 92704 | Fax: (714) 966-2438 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M-F 8:30am-5:30pm
Provider Languages: Thai, Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Oranee E. Chai, M.D. | **General Practice** | **(0-21 years)**
Bristol McFadden Medical Group
1212 S. Bristol St., Suite 16 | Tel: (714) 966-0646 | **CCS: No**
Santa Ana, CA 92647 | Fax: (714) 966-2438 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M-F 8:30am-5:30pm
Provider Languages: Thai, Spanish
Staff Languages: Spanish, Thai
Hospital Privileges: Admit Panel

Mirna R. Chambi, M.D. | **Family Medicine** | **(0-100 years)**
7151 Lincoln Ave., Suite A&B | Tel: (714) 821-6506
Buena Park, CA 90620 | Fax: (714) 229-0476
CCS: No

Board Certified: Y | **CHDP: No**
Hours: M-F 9am-6pm | **CPSP: No**
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Rachel J. Chin, D.O. | **Pediatrics** | **(0 – 18 years)**
StrongKids Medical Group, Inc. dba Strong Families Medical Group, Inc.
2222 S. Main St. | Tel: (714) 542-1331 | **CCS: Yes**
Santa Ana, CA 92707 | Fax: (714) 542-4758 | **CHDP: Yes**
CPSP: No

Board Certified: N
Hours: M-F 9am-6pm
Languages: Spanish, Korean
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Medical Center, South Coast Medical Center.

Second Office: 12665 Garden Grove Blvd. Suite # 713 Tel: (714) 537-6595
Garden Grove, CA 92813 Fax: (714) 537-2176

Raman Chopra, M.D. | **Pediatrics** | **(0-21 years)**
Janak R. Chopra, MD, Inc.
12555 Garden Grove Blvd., Suite 404
Garden Grove, CA 92843
Tel: (714) 638-0232
Fax: (714) 638-0821
CCS: No
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm
Provider Languages: Hindi, Punjabi
Staff Languages: Spanish, Hindi, Punjabi
Hospital Privileges: Garden Grove Hospital & Medical Center, St. Joseph Hospital-Orange

Anthony Chuang, M.D. | **Pediatrics** | **(0-18 years)**
Family Choice Pediatrics
3801 Katella Ave., Suite 221
Los Alamitos, CA 90720
Tel: (562) 431-6548
Fax: (714) 761-2086
CCS: No
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-F 9am-5:30pm; 1st Sat of the Month 9am-1pm
Staff's Languages: Spanish
Hospital Privileges: Fountain Valley Reginal Hospital, Millers Children's and Women's Hospital of Long Beach

Jose R. Cilliani, D.O. | **Family Medicine** | **(All Ages)**
Popular Medical Clinic, Inc.
420 S. Bristol St.
Santa Ana, CA 92703
Tel: (714) 541-5252
Fax: (714) 541-1402
CCS: No
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm; Sat 9am-12pm
Provider Languages: Spanish, German
Staff Languages: Spanish, German
Hospital Privileges: Admit Panel

Ana Reya A. Concepcion-Medina, M.D. | **Pediatrics** | **(0-21 years)**
Kids-Care Medical Group, Inc.
947 S. Anaheim Blvd., Suite 200
Anaheim, CA 92805
Tel: (714) 758-2858
Fax: (714) 778-3723
CCS: No
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-F 9am-4:30pm
Provider Languages: Spanish
Staff Languages: Spanish, Tagalog
Hospital Privileges: Anaheim Global Medical Center, Orange County Global Medical Center

2nd Address:
1164 N. Euclid St.
Anaheim, CA 92801
Tel: (714) 778-0631
Fax: (714) 778-3437
Hours: M-F 9am-4:30pm
Staff Languages: Tagalog, Spanish

Trung D. Dao, M.D. | **Family Medicine** | **(All Ages)**
9211 Bolsa Ave., Suite 217
Westminster, CA 92683
Tel: (714) 898-7886
Fax: (714) 898-8226
CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M, T, Th, F 10am-6pm; Sat 10am-2pm
Provider Languages: Vietnamese, Cambodian
Staff Languages: Vietnamese, Cambodian, French
Hospital Privileges: Admit Panel

Margaret M. De Sa, M.D. | **Pediatrics** | **(0-21 years)**
Kids-Care Medical Group, Inc.
1125 E. 17th St., Suite N-351 | Tel: (714) 480-0044 | **CCS: No**
Santa Ana, CA 92701 | Fax: (714) 480-0060 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-4:30pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Orange County Global Medical Center, Anaheim Global Medical Center, Anaheim Regional Medical Center

2nd Address
947 S. Anaheim Blvd., Suite 200 | Tel: (714) 758-2858
Anaheim, CA 92805 | Fax: (714) 778-3723
Hours: M-F 9am-4:30pm

3rd Address:
1164 N. Euclid St. | Tel: (714) 778-0631
Anaheim, CA 92801
Hours: M-F 9am-4:30pm

Chinh T. Dinh, M.D. | **Family Medicine** | **(All Ages)**
Knott-Ball Anaheim Medical Clinic
3414 W. Ball Rd., Suite F | Tel: (714) 761-9137 | **CCS: No**
Anaheim, CA 92804 | Fax: (714) 761-7034 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm
Provider Languages: Vietnamese
Staff Languages: Spanish, Vietnamese
Hospital Privileges: Admit Panel

Victor H. Dinh, M.D. | **Family Medicine** | **(9 years and older)**
Bolsa Ward Medical Clinic
9746 Westminster Ave., Suite D | Tel: (714) 530-0776 | **CCS: No**
Garden Grove, CA 92844 | Fax: (714) 530-0777 | **CDHP: No**
CPSP: No

Board Certified: Y
Hours: M, T, Th, F 9:30am-6pm; W, Sat 9:30am-3pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Admit Panel

Jaclynn J. Do, M.D. | **Family Medicine** | **(All Ages)**
8070 Westminster Ave., Suite A | Tel: (714) 899-9898
Westminster, CA 92683 | Fax: (714) 316-1389
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-6pm; Sat 9am-1pm | **CPSP: No**
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Antonio Gancayo, M.D. | **Pediatrics** | **(0-18 years)**
Kids-Care Medical Group, Inc.
1164 N. Euclid St. | Tel: (714) 778-0613 | **CCS: No**
Anaheim, CA 92801 | Fax: (714) 778-3437 | **CHDP: Yes**
CPSP: No

Board Certified: Y
Hours: M-F 9am-4:30pm
Languages: Spanish
Hospital Privileges: Orange County Global Medical Center

2nd Address:
947 S. Anaheim Blvd., Suite 200 | Tel: (714) 758-2858
Anaheim, CA 92805 | Fax: (714) 758-3723
Hours: M-F 9am-4:30pm

3rd Address:
1125 E. 17th St., Suite N351 | Tel: (714) 480-0044
Santa Ana, CA 92701 | Fax: (714) 480-0060

Mamerto G. Garcia, M.D. | **Pediatrics** | **(0-18 years)**
Pediatric Medical Associates of Orange County
1211 W. La Palma Ave., Suite 401 | Tel: (714) 520-0313 | **CCS: Yes**
Anaheim, CA 92801 | Fax: (714) 520-0896 | **CHDP: Yes**
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Languages: Spanish, Tagalog
Hospital Privileges: Anaheim Global Medical Center, Anaheim Regional Medical Center

Asaad Hakim, M.D. | **Internal Medicine / Hospitalist** | **(All Ages)**
Pathway Medical Group
12665 Garden Grove Blvd., Suite 502A | Tel: (714) 537-7800
Garden Grove, CA 92843 | Fax: (714) 537-7633

Board Certified: Y
Hours: M-F 8:30am-5pm
Languages: Arabic, Spanish
Hospital Privileges: South Coast Global Medical Center, Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center

John C. Hiserodt, M.D. | **General Practice** | **(All Ages)**
De La Paz Medical Centre, Inc.
934 S. Euclid St. | Tel: (714) 252-0224
Anaheim, CA 92802 | Fax: (714) 254-0234

Board Certified: Yes
Hours: M-F 9am-6pm; Sat 9am-2pm
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Kenneth B. Horwitz, M.D. | **Internal Medicine** | **(18 years and older)**
Chest & Critical Care Consultants Medical Group
1211 W. La Palma Ave., Suite 404 | Tel: (714) 772-8282 | **CCS: No**
Anaheim, CA 92801 | Fax: (714) 772-6493 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5pm
Languages: Spanish, Romanian
Hospital Privileges: Anaheim Regional Medical Center

Julie Hwynn, M.D. | **Internal Medicine** | **(16-64 years)**
Garden Grove Primary Care Medicine
12555 Garden Grove Blvd., Suite 301 | Tel: (714) 741-0501 | **CCS: No**
Garden Grove, CA 92843 | Fax: (714) 741-0095 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Languages: Vietnamese, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center

Yousef W. Ireifej, M.D. | **Family Medicine** | **(3 years and older)**
Pathway Medical Group, Inc.
12665 Garden Grove Blvd., Suite 502A
Garden Grove, CA 92843
Tel: (714) 537-7800
Fax: (714) 537-7633
CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 9am-5pm
Provider Languages: Spanish, Arabic
Staff Languages: Spanish
Hospital Privileges: Admit Panel, Huntington Beach Hospital

Ron Javdan, M.D. | **Internal Medicine**
Benevolence Industries, Inc.
805 W. La Veta Ave., Suite 110
Orange, CA 92868
Tel: (714) 289-8800
Fax: (714) 633-9928
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm; Sat 9am-3pm
Provider Languages: Farsi
Staff Languages: Spanish
Hospital Privileges: Utilize Admit Panel

Abdul A. Khan, M.D. | **Internal Medicine** | **(All Ages)**
Newport Mesa Medical Group
275 Victoria St., Suite 1E
Costa Mesa, CA 92627
Tel: (949) 574-3615
Fax: (949) 534-0537
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M 9am-6pm; T-F 8:30am-5:30pm
Provider Languages: Urdu
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Huntington Beach Hospital, Hoag Memorial Hospital Presbyterian

Munazza Khan, M.D. | **Internal Medicine** | **(10 years and older)**
Newport Mesa Medical Group
275 Victoria St., Suite 1E
Costa Mesa, CA 92627
Tel: (949) 574-3615
Fax: (949) 534-0537
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M 9am-6pm; T-F 9am-5pm
Provider Languages: Urdu, Hindi
Staff Languages: Spanish
Hospital Privileges: Admit Panel, Fountain Valley Regional Hospital & Medical Center, Hoag Memorial Hospital Presbyterian

Pat T. Kouwabunpat, M.D. | **Family Medicine** | **(All Ages)**
1610 W. Edinger Ave., Suite B
Santa Ana, CA 92704
Tel: (714) 641-1610
Fax: (714) 641-1146
CCS: Yes
CHDP: Yes
CPSP: Yes

Board Certified: Y
Hours: M, T, Th, F 8:30am-5pm; W 8:30am-12pm; Sat 9am-12pm
Staff Languages: Spanish, Thai, Vietnamese
Hospital Privileges: South Coast Global Medical Center

Trang T. Lam, M.D. | **Internal Medicine** | **(5-99 years)**
Nhan Hoa Comprehensive Healthcare Clinic
7761 Garden Grove Blvd.
Garden Grove, CA 92841
Tel: (714) 898-8888
Fax: (714) 901-7580
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Admit Panel

Jennifer P. Larson, M.D. | **Family Medicine** | **(55 years and older)**
Ajay G. Meka, M.D., Inc.
606 S. Euclid St. | Tel: (714) 635-8570 | **CCS: Yes**
Anaheim, CA 92802 | Fax: (714) 991-3081 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5:30pm
Staff Languages: Spanish
Hospital Privileges: Admit Panel

2nd Address:
1042 E. Chapman Ave. | Tel: (714) 744-4044
Orange, CA 92866 | Fax: (714) 602-9224
Hours: M-Thurs 9am-5pm

3rd Address:
2740 S. Bristol St., Suite 208 | Tel: (714) 979-5734
Santa Ana, CA 92704 | Fax: (714) 979-5781

4th Address:
201 S. Broadway St. | Tel: (714) 571-4941
Santa Ana, CA 92701

5th Address:
17822 Beach Blvd., Suite 215 | Tel: (714) 847-2576
Huntington Beach, CA 92647 | Fax: (714) 842-2593
Hours: M-Thurs 9am-5pm

Cynthia V. Lavadia, M.D. | **Pediatrics** | **(0-18 years)**
Walsh Medical Group, A Professional Corp
1110 W. La Palma Ave., Suite 6 | Tel: (714) 502-1144 | **CCS: Yes**
Anaheim, CA 92801 | Fax: (714) 502-1146 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-Th 9am-5pm; F 9am-2pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Anaheim Global Medical Center, Orange County Global Medical Center

2nd Address:
947 S. Anaheim Blvd., Suite 115 | Tel: (714) 533-7320
Anaheim, CA 92805 | Fax: (714) 533-7321
Hours: M-Th 9am-5pm; F 9am-2pm
Staff Languages: Spanish

John Le, D.O. | **Family Practice** | **(0-17 years)**
27800 Medical Center Rd., Suite 204
Mission Viejo, CA 92691 | Tel: (949) 364-3532

Board Certified: Y | Fax: (949) 347-7645
Hours: M-Thur 9:30am-5pm; Fri 8am-4pm
Provider Languages: English, Vietnamese, Spanish
Staff Langauges: English, Spanish
Hospital Privileges: Admit Panel

Shelley Y. Lee, M.D. | **Pediatrics** | **(Panel Closed to New Medi-Cal Mbrs Eff 4/22/16)**
Sunshine Pediatric, Inc. | **(0-18 years)**
12665 Garden Grove Blvd., Suite 604 | Tel: (714) 537-8777
Garden Grove, CA 92843 | Fax: (714) 537-8111

CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 8:30am-5pm | **CPSP: No**
Provider Languages: Korean, Spanish
Staff Languages: Spanish, Korean
Hospital Privileges: Garden Grove Hospital & Medical Center

Lawrence Lerno, M.D. | **Internal Medicine** | **(55 years and older)**
Ajay G. Meka, M.D., Inc. Amistad Medical Clinics
17822 Beach Blvd., Suite 215
Huntington Beach, CA 92647
Tel: (714) 847-2576
Fax: (714) 842-2593

Board Certified: Yes
Hours: M-F 9am-6pm
Staff Languages: Spanish, Hindi
Hospital Privileges: Admit Panel

Melissa R. Manalo, M.D. | **Pediatrics** | **(0-17 years)**
3400 W. Ball Rd., Suite 206
Anaheim, CA 92804
Tel: (714) 826-2380
Fax: (714) 826-2873

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M, T, Th, F 9am-5pm; W 9am-1pm; Sat by appt
Provider Languages: Spanish, Tagalog
Staff Languages: Spanish, Tagalog
Hospital Privileges: Anaheim Global Medical Center

Barry Russel Marfleet, M.D. | **General Practice** | **(55 years and older)**
Seniors First Medical Clinics, Inc. | **MEDICARE ONLY**
1042 E. Chapman Ave.
Orange, CA 92866
Tel: (714) 744-4044
Fax: (714) 602-9224

Board Certified: No
Hours: M-Thurs 9am-5pm
Hospital Privileges: Admit Panel

Catherine Marks, M.D. | **Family Medicine** | **(All Ages)**
Santa Marya Family Medicine Clinic
3400 W. Ball Rd., Suite 202
Anaheim, CA 92804
Tel: (714) 236-9663
Fax: (714) 644-8212

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 9am-5pm
Provider Languages: Arabic, some Spanish, some French
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Ajay G. Meka, M.D. | **Internal Medicine** | **(55 years and older)**
2740 S. Bristol St., Suite 208
Santa Ana, CA 92704
Tel: (714) 979-5734
Fax: (714) 979-5781

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-6pm; Sat 8am-4pm
Languages: Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center; Fountain Valley Regional Hospital & Medical Center

2nd Address:
606 S. Euclid Ave.
Anaheim, CA 92802
Tel: (714) 635-8570
Fax: (714) 991-3081
Hours: M-W 8:30am-5:30pm; Th-Sat 9am-1pm

3rd Address:
1510 E. 7th St.
Long Beach, CA 90813
Tel: (562) 590-9800
Fax: (562) 590-9880

Meena K. Meka, M.D. | **Internal Medicine** | **(55 years and older)**
2740 S. Bristol St., Suite 208
Santa Ana, CA 92704
Tel: (714) 979-5734
Fax: (714) 979-7157

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M, T, Th, F 9am-6pm; Sat 8am-2pm
Provider's Languages: Spanish
Staff's Languages: Spanish, Hindi, Gujarati, Chinese, Tagalog
Hospital Privileges: St. Mary Medical Center

2nd Address:
606 S. Euclid Ave.
Anaheim, CA 92802
Tel: (714) 635-8570
Fax: (714) 991-3081
Hours: M, T, W 9am-6pm; F, Sat 9am-1pm

Chester D. Mojica, M.D. | **Family Medicine** | **(18 years and older)**
Central City Community Health Center
12511 Brookhurst St
Garden Grove, CA 92840
Tel: (714) 643-7176
Fax: (714) 643-7180

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Minsen Mok, M.D. | **Internal Medicine** | **(All Ages)**
11100 Warner Ave. Suite 362
Fountain Valley, CA 92708
Tel: (714) 434-4990
Fax: (714) 434-4972

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 9am-5pm
Provider Languages: Cantonese, Vietnamese
Staff Languages: Spanish, Vietnamese
Hospital Privileges: Admit Panel, Fountain Valley Regional Hospital & Medical Center

Assanassios Moussa-Faltas, M.D. | **Family Medicine** | **(All Ages)**
Santa Marya Family Medicine Clinic
3400 W. Ball Rd., Suite 202
Anaheim, CA 92804
Tel: (714) 236-9663
Fax: (714) 644-8212

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 9am-5pm
Provider Languages: Arabic, French, some Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Duc Huu Nguyen, D.O. | **Family Medicine** | **(All Ages)**
Nhan Hoa Comprehensive Healthcare Clinic
7761 Garden Grove Blvd.
Garden Grove, CA 92841
Tel: (714) 898-8888
Fax: (714) 908-8097

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-8pm; Sat 9am-1pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Admit Panel

Thanh Q. Nguyen, M.D. | **Pediatrics** | **(0-21 years)**
TQ Pediatrics, Inc.
10900 Warner Ave., Suite 118
Fountain Valley, CA 92708
Tel: (714) 968-7938
Fax: (714) 968-7990

CCS: Yes
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 8am-5pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Tramy T. Nguyen-Mok, M.D. | **Pediatrics** | **(0-21 years)**
11100 Warner Ave. Suite 362 | Tel: (714) 434-4990
Fountain Valley, CA 92708 | Fax: (714) 434-4972

CCS: Yes
Board Certified: Y | **CHDP: No**
Hours: M, T, T, F 9am-5pm | **CPSP: No**
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Admit Panel, Fountain Valley Regional Hospital & Medical Center

Nancy M. Obena, M.D. | **Pediatrics** | **(0-18 years)**
Walsh Medical Group, A Professional Corp
1110 W. La Palma Ave., Suite 6 | Tel: (714) 502-1144 | **CCS: No**
Anaheim, CA 92801 | Fax: (714) 502-1146 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-Th 9am-5pm; F 9am-2pm
Provider Languages: Tagalog
Staff Languages: Spanish
Hospital Privileges: Anaheim Global Medical Center, Orange County Global Medical Center

2nd Address:
947 S. Anaheim Blvd., Suite 115 | Tel: (714) 533-7320
Anaheim, CA 92805 | Fax: (714) 533-7321
Hours: M-Th 9am-5pm; Sat 9am-2pm
Staff Languages: Tagalog

Paola Pare, D.O. | **Pediatrics** | **(0 – 18 years)**
Paramount Care Medical Group, Clinic for Women & Children
111 W. 17th Street | Tel: (714) 647-1300
Santa Ana, CA 92706 | Fax: (714) 667-3430

Board Certified:
Hours: M-F 9am-6pm; Sat 9am-1pm
Provider's Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Provider

Kaylee Rae Parsons, D.O. | **Pediatrics** | **(0 – 18 years)**
Pediatrics & Neonatology Medical Group of Orange County, Inc.
12665 Garden Grove Blvd. Suite 713 | Tel: (714)537-6595
Garden Grove, CA 92843 | Fax: (714) 537-2176

CCS: Yes
Board Certified: Yes | **CPSP: Yes**
Hours: M-F 9am-6pm; Sat 9am-1pm | **CPSP: No**
Staff Languages: Spanish
Hospital Privileges: Admit Panel

2nd Location:
StrongKids Medical Group, Inc. dba Strong Families Medical Group, Inc
1491 E. La Palma Ave. | Tel: (714) 535-3330
Anaheim, CA 92805 | Fax: (714) 535-4332
Hours: M-F 9am-6pm; Sat 9am-1pm

3rd Location:
StrongKids Medical Group, Inc. dba Strong Families Medical Group, Inc
2222 S. Main St. | Tel: (714) 542-1331
Santa Ana, CA 92707 | Fax: (714) 542-4758
Hours: M-F 9am-6pm; Sat 9am-1pm

Hitesh C. Patel, M.D. | **Family Medicine** | **(All Ages)**
7915 Westminster Blvd. | Tel: (714) 891-4549
Westminster, CA 92683 | Fax: (714) 898-7419

CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-6pm; Sat 9am-1pm | **CPSP: No**
Staff Languages: Hindi, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center

Rosemary D. Reyes, D.O. | **Family Medicine** | **(All Ages)**
Central City Community Health Center
2237 W. Ball Rd. | Tel: (714) 490-2750 | **CCS: No**
Anaheim, CA 92804 | Fax: (714) 490-2757 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm; Sat 9am-3pm
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Efren G. Rodriguez, M.D. | **Pediatrics** | **(0-18 years)**
Kids Care Pediatrics Medical Group
947 S. Anaheim Blvd., Suite 200 | Tel: (714) 758-2858 | **CCS: No**
Anaheim, CA 92805 | Fax: (714) 758-3723 | **CHDP: Yes**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Languages: Spanish
Hospital Privileges: Anaheim Global Medical Center, Anaheim Regional Medcial Center, Orange County Global Medical Center

2nd Address:
1164 N. Euclid St., | Tel: (714) 778-0613
Anaheim, CA 92801 | Fax: (714) 778-2098
Hours: M-F 9am-5pm
Staff Languages: Spanish

3rd Address:
1125 E. 17th St. | Tel: (714) 480-0044
Santa Ana, CA 92701 | Fax: (714) 480-0060
Hours: M-F 9am-5pm
Staff Languages: Spanish

Theodore G. Rose, MD | **Internal Medicine** | **(10 years and older)**
Pathway Medical Group
12462 Brookhurst St., Suite A & B | Tel: (714) 636-9850 | **CCS: No**
Garden Grove, CA 92840 | Fax: (717) 636-1248 | **CHDP: No**
CPSP: No

Board Certified:Y
Hours: M-F 9am – 5pm
Staff Languages: Spanish
Hospital Privileges: Huntington Beach Hospital, West Anaheim Medical Center, Garden Grove Hospital

Lucy M. Saenz, M.D. | **General Practice** | **(Medi-Cal 65+, Medicare, ACA & disabled)**
1215 E. 17th St. | Tel: (714) 547-4411
Santa Ana, CA 92701-2641 | Fax: (714) 547-4222
CCS: No

Board Certified: N
Hours: M 8am-5pm; T 12pm-7pm; W, Th 9am-5pm; F 7am-2pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Panel

2nd Address:
1203 N. Euclid Ave. | Tel: (714) 224-3388
Anaheim, CA 92701 | Fax: (714) 224-3378
Hours: M-Th 9am-5pm; F 9am-1pm
Staff Languages: Spanish

Mercedes B. Samson, M.D. | **General Practice** | **(All Ages)**
Hana Medical Group, Inc.
8615 Knott Ave., Suite 3 | Tel: (714) 527-4833 | **CCS No**
Buena Park, CA 90620 | Fax: (714) 527-5986 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M-F 9am-6pm, Sat 8:30am-1pm
Provider Languages: Tagalog, Spanish
Staff Languages: Tagalog, Spanish
Hospital Privileges: Admit Panel

Praful A. Sarode, M.D. | **Pediatrics / General Practice** | **(0-21 years)**
17456 Beach Blvd., Suite 101
Huntington Beach, CA 92647
Tel: (714) 847-8551
Fax: (714) 316-1261

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-Sat 8am-5pm
Provider Languages: Hindi
Staff Languages: Hindi, Spanish, Urdu
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Children's Hospital of Orange County, Orange County Global Medical Center

2nd Address:
999 N. Tustin Ave., Suite 124
Santa Ana, CA 92705
Tel: (714) 547-5444
Fax: (714) 829-3002
Hours: M-F 9am-5pm
Staff Languages: Spanish, Hindi, Urdu

Joseph A. Serna, M.D. | **General Practice** | **(18 years and older)**
1220 W. Hemlock Way, Suite 112
Santa Ana, CA 92707
Tel: (714) 545-5503
Fax: (714) 545-5509
CLOSED PANEL

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 12pm-7pm
Staff Languages: Spanish
Hospital Privileges: South Coast Global Medical Center, Fountain Valley Regional Hospital & Medical Center

Farrokh Shadab, M.D. | **Pediatrics** | **(0-21 years)**
11180 Warner Ave., Suite 169
Fountain Valley, CA 92708
Tel: (714) 549-1200
Fax: (714) 549-3238

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-6pm
Provider Languages: Farsi
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Hoag Memorial Hospital Presbyterian, Mission Hospital Regional Medical Center, Saddleback Memorial Medical Center, Orange Coast Memorial Medical Center

Homa Shoghian, M.D. | **Family Medicine** | **(All Ages)**
AVA Medical Group
1329 W. Warner Ave.
Santa Ana, CA 92704
Tel: (714) 444-0044
Fax: (714) 444-0043

CCS: No
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-Th 9am-6pm; F 9am-2pm
Provider Languages: Farsi
Staff Languages: Spanish
Hospital Privileges: South Coast Global Medical Center

Navneet Singh, D.O. | **Internal Medicine** | **(16 years and older)**
Strong Families Medical Group, Inc
2222 S Main Street
Santa Ana, CA 92707
Tel: (714) 537-7500
Fax: (714) 537-2176

CCS: Yes
CHDP: No
CPSP: No

Board Certified:
Hours: M-F 9:00am – 5:00pm; Sat 10:00am – 1:00pm
Provider Languages: Hindi, Punjabi
Staff's Languages: Spanish, Vietnamese
Hospital Privileges: Admit Panel

Ryan Smith, M.D. | **Pediatrics** | **(0-18 years old)**
Pediatric & Neonatology Medical Group of Orange County, Inc.
12665 Garden Grove Blvd., Suite 713
Garden Grove, CA 92843
Tel: (714) 537-7500
Fax: (714) 537-2176

CCS: Yes
CHDP: Yes
CPSP: No

Board Certified: N
Hours: M-F 8:30am-6pm, Sat 9am-1pm
Provider Language: Spanish
Staff Languages: Spanish, Korean, Tagalog

Alexander J. Sweidan, M.D. — **Internal Medicine** — **(16 years and older)**
Strong Families Medical Group, Inc
2222 S. Main St. — Tel: (714) 537-7500
Santa Ana, CA 92707 — Fax: (714) 537-2176

CCS: Yes
CHDP: No
CPSP: No

Provider Languages: Romanian, Polish, Spanish
Staff Languages: Spanish, Vietnamese
Hours: M-F 9:00am – 5:00pm; Sat 10:00am – 1:00pm
Hospital Privileges: Hoag Memorial Hospital Presbyterian, Fountain Valley Regional Hospital

2nd Address: 1491 E. La Palma Ave., Suite B — Tel: (714) 535-3330
Anaheim, CA 92805 — Fax: (714) 535-4332
Hours: M-F 9:00am – 5:00pm; Sat 9:00am – 1:00pm

Jacob Sweidan, M.D. — **Pediatrics / General Practice** — **(0-18 years)**
Pediatric & Neonatology Medical Group of Orange County, Inc.
12665 Garden Grove Blvd., Suite 713 — Tel: (714) 537-6595 or (714) 537-7500
Garden Grove, CA 92843 — Fax: (714) 537-2176

CCS: Yes
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm; Sat 9am-1pm
Provider Languages: Spanish, Romanian
Staff Languages: Spanish, Korean
Hospital Privileges: Garden Grove Hospital & Medical Center, South Coast Global Medical Center, Fountain Valley Regional Hospital & Medical Center, Orange County Global Medical Center, Orange Coast Memorial Medical Center, Children's Hospital of Orange County, Hoag Memorial Hospital Presbyterian, UCI Medical Center

2nd Address:
StrongKids Medical Group, Inc. dba Strong Families Medical Group, Inc. — **(All Ages)**
2222 S. Main St. — Tel: (714) 542-1331
Santa Ana, CA 92707 — Fax: (714) 542-4758
Hours: M-F 9am-6pm; Sat 9am-1pm
Staff Languages: Spanish, Korean, Tagalog, Vietnamese

3rd Address:
StrongKids Medical Group, Inc. dba Strong Families Medical Group, Inc. — **(All Ages)**
1491 E. La Palma Ave., Suite B — Tel: (714) 535-3330
Anaheim, CA 92805 — Fax: (714) 535-4332
Hours: M-F 9am-6pm
Staff Languages: Spanish, Korean, Tagalog

Kwan T. Tan, M.D. — **Internal Medicine** — **(All Ages)**
Joshua International Medical Group
7872 Walker St., Ste. 100 — Tel: (714) 527-8777/(562) 809-5674
La Palma, CA 90623 — Fax: (714) 527-8990/(714) 256-2431

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M, T, W, Th 8:30am-6pm; F 8:30am-5pm Sat 9am-1pm
Provider Languages: Cantonese
Staff Languages: Spanish, Mandarin, Cantonese
Hospital Privilegies: Los Alamitos Medical Center

Christine H. Tran, M.D. — **Pediatrics** — **(0-21 years)**
12665 Garden Grove Blvd., Suite 204 — Tel: (714) 537-7373
Garden Grove, CA 92843 — Fax: (714) 537-7744

CCS: Yes
CHDP: No
CPSP: No

Board Certified: N
Hours: M-Th 9am-5pm; F 9am-6pm; Sat 9am-1pm
Languages: Spanish, Vietnamese, French
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center

Timothy T. Tran, M.D. — **Family Medicine** — **(All Ages)**
12302 Garden Grove Blvd., Suite 7 — Tel: (714) 537-4343
Garden Grove, CA 92843 — Fax: (714) 537-5543

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M, T, Th, F 9am-6pm; Sat 9:30am-3pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese, French, Spanish
Hospital Privileges: Admit Panel

UC Irvine Family Health Center Anaheim
Location Will Open 08/31/2020
2441 W. La Palma Ave
Anaheim, CA 92801
Tel: (888) 456-7002
Fax: (714) 973-2825

Hours: M-F 9am-6pm

UC Irvine Family Health Center Santa Ana
800 N. Main St.
Santa Ana, CA 92701
Tel: (888) 456-7002
Fax: (714) 535-5407

Hours / Family Medicine: M, T 7:30am-8pm; W, Th 7:30am-7pm; F 7:30am-5pm
Hours / Pediatrics: M, T 8am-8pm; W, Th 8am-7pm; F 8am-5pm

Winston C. Wong, M.D. — **Pediatrics** — **(All Ages)**
Joshua International Medical Group
7872 Walker St., Ste. 211
La Palma, CA 90623
Tel: (714) 527-8777/(562) 809-5674
Fax: (714) 527-9086/(562)809-7447
CCS: Yes
CHDP: No
CPSP: No

Board Certified: N
Hours: M, W, F 8am-5pm; T, Th 8:30am-7pm; Sat 9am-1pm
Provider Languages: Cantonese, Mandarin
Hospital Privileges: Los Alamitos Medical Center

Derek J. Wu, M.D. — **Pediatrics** — **(0-21 years)**
3801 Katella Ave., Suite 221
Los Alamitos, CA 90720
Tel: (562) 431-6548
Fax: (714) 761-2086
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Cantonese
Staff Languages: Spanish, Cantonese
Hospital Privileges: Admit Panel

Angeline Yatar-Ituriaga, M.D. — **Pediatrics** — **(0-18 years)**
515 S. Beach Blvd., Suite I
Anaheim, CA 92804
Tel: (714) 952-4147
Fax: (714) 952-2620
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M, Th 9am-6pm; W, F 8:30am-5:30pm
Provider Languages: Tagalog
Staff Languages: Tagalog, Spanish
Hospital Privileges: Anaheim Regional Medical Center, Anaheim Global Medical Center, Orange County Global Medical Center

Crystal Ss Yee, M.D. — **Pediatrics** — **(0-21 years)**
Pediatrics & Neonatology Medical Group of Orange County
12665 Garden Grove Blvd., Suite 713
Garden Grove, CA 92843
Tel: (714) 537-6595
Fax: (714) 537-2176
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm; Sat 9am-1pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid-Orange County
c/o HealthSmart Management Services Organization, Inc.

P.O. Box 6300, Cypress, CA 90630-0063
(888) 880-8811; (714) 947-8600; UM Fax (800) 934-9700

Specialty Care Physicians: **8/2/2023**

Yoorim E. Choi, D.C., L.A.C. — **Acupuncture/Chiropractic** — **(All Ages)**
18111 Brookhurst St., Suite 6300
Fountain Valley, CA 92708
Tel: (714) 847-6727
Fax: (714) 847-6643
CCS: No
CHDP: No
CPSP: No

Hours: M, W 8am-12pm, T 2pm-6pm, Th 12pm-7pm, F 8am-5pm
Provider Languages: Korean
Staff Languages: Spanish, Tagalog

Brian Lee, L.A.c. — **Acupuncture** — **(All Ages)**
Cornerstone Acupuncture Institute
15785 Laguna Canyon Rd., Suite 330
Irvine , CA 92618
Tel: (949) 424-6430
Fax: (949) 612-0010
CCS: No
CHDP: No
CPSP: No

Hours: M-F 9am-5pm
Provider Languages: Korean
Staff Languages: Spanish, Korean

2nd Adress:
150 Laguna Road, Suite A. Tel: (949) 424-6430
Fullerton, CA 92835 Fax: (949) 612-0010

Van H Nguyen, L.A.c. — **Acupuncture** — **(All Ages)**
15581 Brookhurst St.
Westminster, CA 92683
Tel: (714) 725-2946
Fax: (714) 379-0860
CCS: No
CHDP: No
CPSP: No

Hours: M-F 9:00am -6:00pm
Provider Languages: Vietnamese

Roger L. Nguyen, M.D. — **Allergy & Immunology** — **(All Ages)**
9746 Westminster Ave., Suite A
Garden Grove, CA 92844
Tel: (714) 638-4433
Fax: (714) 638-4499
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: T, F 9am-5pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Admit Panel

Sherwin A. Basil, A.U.D. — **Audiology** — **(All Ages)**
Riverview Hearing, Speech & Language Center
2100 South Euclid Street, Suite 101
Anaheim, CA 92802
Tel: (714) 748-4327
Fax: (714) 233-5965
CCS: No
CHDP: No
CPSP: No

Hours: M-F 9am-5pm; Sat 9am-1pm
Staff's Languages: Spanish, Vietnamese, Tagalog

2nd Address: 2100 S. Euclid St. Tel: (562) 439-9539
Suite 101 Fax: (657) 233-5965
Anaheim, CA 92802
Hours: M-F 9a-5p

Reginald G.M. Abraham, M.D. | **Cardiovascular Surgery** | **(18 years and older)**
Thoracic Surgery

11100 Warner Ave., Suite 258 | Tel: (714) 549-5990 | **CCS: No**
Fountain Valley, CA 92708 | Fax: (714) 845-0041 | **CHDP: No**
CPCP: No

Board Certified: Y
Hours: M, T, Th, F 9am-4pm; W 9a-12pm
Provider Languages: French, Spanish, Tamil, Chinese, Malay
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, UCI Medical Center, Chapman Global Medical Center, Orange County Global Medical Center, Orange Coast Memorial Medical Center, Hoag Memorial Hospital Presbyterian, Good Samaritan Hospital, Saddleback Memorial Medical Center, Long Beach Memorial Medical Center

John Baker, MD | **Cardiovascular Diseases** | **(All Ages)**
Cardiology Consultants of OC Medical Group
801 N. Tustin Ave, Ste 706 | Tel: (714) 568-6600
Santa Ana, CA 92705 | Fax: (714) 245-0881

Board Certified: Yes
Hours: M-F 8am-5pm
Provider Languages: Korean, Spanish
Staff Languages: Spanish
Hospital Privileges: Anaheim Regional Medical Center, Foothill Regional Medical Center, Fountain Valley Regional Medical Center, Hoag Memorial Hospital, Orange County Global Medical Center, Placentia-Linda Community Hospital

2nd Address: 1801 W Romneya Dr, Ste 403
Anaheim, CA 92801
Hours: M-F 8am-5pm | Fax: (714) 245-0260

3rd Address: 1325 Rose Dr, Ste 208
Placentia, CA 92870
Hours: T-Th 8:30am-5pm

Majed Chane, M.D. | **Cardiovascular Disease** | **(All Ages)**
California Heart Specialist, Inc
18800 Main Street, Suite 103 | Tel: (714) 842-8100 | **CSS: Yes**
Huntington Beach, CA 92648 | Fax: (714) 842-8181 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Arabic, Spanish
Staff Languages: Spanish, Arabic, Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Huntington Beach Hospital, Hoag Memorial Hospital Presbyterian, UCI Medical Center

Narayanaiyengar R. Devaraj, M.D. | **Cardiovascular Disease** | **(18 years and older)**
3356 W. Ball Rd., Suite 205 | Tel: (714) 952-0958
Anaheim CA 92804 | Fax: (714) 952-0719
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-S 9am-5pm | **CPSP: No**
Languages: Hindi, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, St. Jude Medical Center

Harinder Singh Gogia, M.D. | **Cardiovascualr Disease** | **(18 years and older)**
Cardiology Consultants of Orange County Medical
801 N.Tustin Ave., Suite 706 | Tel: (714) 568-6600 | **CCS: No**
Santa Ana,CA 90705 | Fax: (714) 245-0881 | **CHDP: No**
CPSP: No

Board Certified: Yes
Hours: M-F 8am – 5pm
Provier Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Foothill Regional Medical Center, Fountain Valley Regional Hospital, Chapman Global Medical Center, Orange County Global, Placentia Linda Hospital, West Anaheim Medical Cneter

2nd Location: 1801 W. Romneya Dr., Suite 403 | Tel: (714) 568-6600
Anaheim, CA 92801 | Fax: (714) 245-0881
Hours: M-F 8am – 5pm

3rd Location: 1325 Rose Dr. Suite 208 | Tel: (714) 568-6600
Placentia, CA 92870 | Fax: (714) 245-0881
Hours: Wed & Thr: 8:30am – 5pm

Ranjit Nihal Goonetilleke, M.D. | **Cardiovascular Disease** | **(12 years and older)**
Ajay G. Meka, M.D., Inc.
201 S. Broadway St. | Tel: (714) 571-4941 | **CCS: Yes**
Santa Ana, CA 92701 | **CHDP: No**
CPSP: No

Board Certified: Yes
Hours: M-F: 9am-6pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Orange County Global Medical Center, Tustin Rehabilitation Hospital

2nd Address:
17822 Beach Blvd., Suite 2018 | Tel: (714) 847-2576
Huntington Beach, CA 92647

Sean Ken Hirota, M.D. | **Cardiovascular Disease** | **(18 years and older)**
Cardiology Consultants of Orange County Medical Group
801 N. Tuston Ave, Suite 706 | Tel: (714) 568-6600
Santa Ana, CA 92705 | Fax: (714) 245-0881

Board Certifed: Yes
Hours: M-F 8:30am-5pm
Staff Languages: Spanish
Hospital Privileges: Anaheim Regional Medical Center, Chapman Global Medical Center, Foothill Regional Medical Center, Orange County Global Medical Center, Placentia-Linda Community Hospital

2nd Location: 1801 W. Romneya Dr., Suite 403 | Tel: (714) 568-6600
Anaheim, CA 92801 | Fax: (714) 245-0881

3rd Location: 1325 Rose Dr. Suite 208 | Tel: (714) 568-6600
Placentia, CA 92870 | Fax: (714) 245-0881

Hemal H. Kadakia, M.D. | **Cardiovascular Disease** | **(12 years and older)**
Ajay G. Meka, M.D., Inc.
201 S. Broadway St. | Tel: (714) 571-4941 | **CCS No**
Santa Ana, CA 92701 | **CHDP: No**
CPSP: No

Board Certified: Yes
Hours: M-F 9am-6pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Hoag Memorial Hospital Presbyterian, Meniffe Valley Medical Center

2nd Address:
17822 Beach Blvd., Suite 2018 | Tel: (714) 847-2576
Huntington Beach, CA 92647

Dinesh Kumar, M.D. | **Cardiovascular Disease** | **(18 years and older)**
Orange County Heart & Vascular, Inc.
1101 Bryan Ave., Suite E.
Tustin, CA 92780
Tel: (714) 617-5163
Fax: (714) 617-5786
CCS: No
CHDP: No
CPSP: No

Hours:
Hospital Privileges: Anaheim Memorial Medical Center, HOAG Memorial Hospital Presbyterian

Steven Khoa-Tran Le, M.D. | **Cardiovascular Disease** | **(18 years and older)**
Steven Khoa-Tran Le, M.D., Inc.
11100 Warner Ave., Suite 114
Fountain Valley, CA92708
Tel: (714) 602-4222
Fax: (714) 602-4221
CCS: No
CHDP: No
CPSP: No

Hours: M-F 9am-6pm; Sat 9am-2pm
Board Certified: Y
Provider's Languages: Vietnamese
Staff's Languages: Vietnamese
Fountain Valley Regional Hospital & Medical Center, Garden Grove Hospital, Orange Coast Memorial Medical Center

Luc Nguyen, M.D. | **Cardiovascular Disease** | **(All Ages)**
14571 Magnolia St., Suite 208
Westminster, CA 92683
Tel: (714) 438-0082
Fax: (714) 438-0072
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm; Sat 9am-1pm
Languages: Vietnamese
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Tung H. Nguyen, M.D. | **Cardiovascular Disease** | **(18 years and older)**
9822 Bolsa Ave., Suite F
Westminster, CA 92683
Tel: (714) 775-7000
Fax: (714) 775-5200
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital, Orange Coast Memorial Medical Center, Huntington Beach Hospital, Kindred Hospital-Westminster

Harishchandra N. Patel, M.D. | **Cardiovascular Disease** | **(18 years and older)**
1211 W. La Palma Ave., Suite 101
Anaheim CA 92801
Tel: (714) 527-7000
Fax: (714) 952-0336
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm
Provider Languages: Spanish, Gujarati
Staff Languages: Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, St. Jude Medical Center, West Anaheim Medical Center, AHMC Anaheim Regional Medical Center

Sami Mohammed Shoukair, M.D. | **Cardiovascular Disease** | **(18 years and older)**
Cardiology Consultants of Orange County Medical Group
801 N. Tustin Ave., Suite 706
Santa Ana, CA 92705
Tel: (714) 568-6600
Fax: (714) 245-0881
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Arabic
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Harpreet Singh, M.D. | **Cardiovascular Disease** | **(18 years and older)**
Heart Center of Orange County Medical Group
11180 Warner Ave., Suite 165 | Tel: (714) 429-5886 | **CCS: No**
Fountain Valley, CA 92708 | Fax: (714) 429-5924 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-Th 9am-5pm; Sat 9am-2pm
Provider Languages: Hindi, Punjabi
Staff Languages: Spanish, Hindi, Punjabi
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, Orange County Global Medical Center, Chapman Global Medical Center, South Coast Global Medical Center, Kindred Hospital–Santa Ana, Kindred Hospital–Westminster, Tustin Rehabilitation Hospital, West Anaheim Medical Center

Syam P. Vunnamadala, M.D. | **Cardiovascular Surgery** | **(18 years and older)**
Thoracic Surgery
1211 W. La Palma Ave., Suite 310 | Tel: (714) 491-3928
Anaheim, CA 92801 | Fax: (714) 491-3960

Board Certified: Y - General Surgey Only
Hours: M-F 8am-4pm
Provider Languages: Hindi, Telugu
Staff's Languages: Arabic
Hospital Privileges: West Anaheim Medical Center, Orange County Global Medical Center, Anaheim Global Medical Center

Yoorim E. Choi, D.C., L.A.C. | **Chiropractic/Acupuncture** | **(All Ages)**
18111 Brookhurst St., Suite 6300 | Tel: (714) 847-6727
Fountain Valley, CA 92708 | Fax: (714) 847-6643

CCS: No
Hours: M, W 8am-12pm, T 2pm-6pm, Th 12pm-7pm, F 8am-5pm | **CHDP: No**
Provider Languages: Korean | **CPSP: No**
Staff Languages: Spanish, Tagalog

Tuan Duc Nguyen, D.C. | **Chiropractic** | **(All Ages)**
10666 Chapman Avenue, Suite 3 | Tel: (714) 554-5304
Garden Grove, CA 92840 | Fax: (714) 554-6052

CCS: No
Hours: M,-F 10am – 4:30pm, S appointment only | **CHDP: No**
Provider Languages: Vietnamese | **CPSP: No**
Staff Languages: Vietnamese

Gary B. Wright, D.C. | **Chiropractic** | **(All Ages)**
Sports & Family Chiropractic | **IN PROCESS**
50 S. Anaheim Blvd. Suite 250 | Tel: (714) 956-2225 | **CCS: No**
Anaheim, CA 92805 | Fax: (714) 956-5350 | **CHDP: No**
CPSP: No

Hours: M, Tue, Wed & Fri 9am-7pm; Sat 9am-1pm
Provider Language: Spanish
Staff Languages: Spanish

Quy V. Le, M.D. | **Colon & Rectal Surgery** | **(15 years and older)**
General Surgery
18225 Brookhurst St., Suite 6 | Tel: (714) 200-1499 | **CCS: YES**
Fountain Valley, CA 92708 | Fax: (714) 200-1497 | **CHDP: NO**
CPSP: NO

Board Certified: Y (General Surgery only)
Hours: M-F 9am-5pm
Provider Languages: Vietnamese
Staff's Languages: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Medical Center, Orange Coast Memorial Medical Center

Carmen Ruiz, M.D. | **Colon & Rectal Surgery** | **(16 years and older)**
Carmen Ruiz, M.D., Inc.
432 E. 10th Street
Long Beach, CA 90813
Tel: (562) 491-7935
Fax: (562) 432-7930

CCS: YES
CHDP: NO
CPSP: NO

Board Certified: Y
Hours: M-F 8:30am-5pm
Provider's Languages: Spanish
Staff's Languages: Spanish, Armenian
Hospital Privileges: Glendale Memorial Hospital and Health Center, Methodist Hospital, St. Mary Medical Center

2nd Address:
301 W. Huntington Dr. Ste. 618
Arcadia, CA 91007
Tel: (626) 898-8234
Fax: (626) 898-8235
Hours: M-F 8:30am-5pm
Staff's Languages: Spanish, Armenian

3rd Address:
222 W. Eulalia St. Suite 100A
Glendale, CA 91204
Tel: (818) 244-8161
Fax: (818) 244-5122
Hours: M-F 8:30am-5pm

Bita A. Bagheri, M.D. | **Dermatology** | **All Ages**
12665 Garden Grove Blvd, Suite 301
Garden Grove, CA 92843
Tel: (949) 252-6966
Fax: (714) 422-0960

Board Certified: Yes
Hours: M-F 8am-5pm
Provider Languages: Farsi
Staff Languages: Spanish
Hospital Privileges: HOAG Memorial Hospital, Riverside Community Hospital, Parkview Community Hospital Medical Center

2nd Address:
520 Superior Ave., Suite 525
Newport Beach, CA 92663
Tel: (949) 236-7900
Fax: (949) 236-7900

Navid Ezra, M.D. | **Dermatology** | **All Ages**
California Dermatology
18433 Roscoe Blvd, Suite 104
Northridge, CA 91325
Tel: (805) 222-5803
Fax: (805) 222-0323

Board Certified: Yes
Hours: M-F 8:30am-5pm
Provider's Languages: Spanish, Farsi
Staff's Languages: Spanish, Farsi

Vivian Laquer, M.D | **Dermatology**
First OC Dermatology
17271 Brookhurst St.
Fountain Valley, CA 92708
Tel: (714) 531-2966
Fax: (714) 531-3495

CCS: Yes
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 9am-5pm,
Provider's Languages: Vietnamese, Spanish, French
Staff's Languages: Vietnamese, Spanish
Hospital Privileges: Hoag Memoral Hospital, Orange Coast Memoral Medical Center

2nd Address:
17305 Von Karman Ave., Suite 107
Irvine, CA 92614
Tel: (949) 679-9994
Fax: (949) 649-9933
Hours: M-F 9am-6pm Sat 9am - 1pm

Gary C. Lee, M.D.
4980 Barranca Parkway, Suite 202
Orange, CA 92868

Dermatology
Tel: (949) 733-1336
Fax: (949) 733-3387

All Ages

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Chinese
Staff Languages: Chinese, Spanish

Annie Liu, M.D.
CSI Medical Group dba California Skin Institute
289 W. Huntington Dr., Suite 208
Arcadia, CA 91007

Dermatology
Tel: (626) 446-8809
Fax: (626) 446-8268

(All Ages)

CCS: No
CHDP: NO
CPSP: NO

Board Certified: Yes
Hours: M-F: 8am-5pm
Hospital Privileges: Admit Panel

2nd Address
800 Fairmont Ave., Ste., 220
Pasadena, CA 91105
Hours: M-F 8am-5pm

Tel: (626) 585-9474
Fax: (626) 585-9480

Tien Quang Nguyen, M.D.
First OC Dermatology
17271 Brookhurst St.
Fountain Valley, CA 92708

Dermatology
Tel: (714) 531-2966
Fax: (714) 531-3495

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm, Sat 9am-1pm
Provider's Languages: Vietnamese, Spanish
Staff's Languages: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Hospital, Garden Grove Hospital, Orange Coast Memorial Medical Center, Hoag Memorial Hospital Presbyterian

2nd Address:
17305 Von Karman Ave., Suite 107
Irvine, CA 92614
Hours: M-F 9am – 6pm Sat 9am – 1pm

Tel: (949) 679-9994
Fax: (949) 649-9933

Sabrina Uddin, M.D.
California Skin Institute
475 S. State College Blvd.
Brea, CA 92821

Dermatology
Tel: (714) 870-7546
Fax: (714) 870-6192

(All Ages)

CCS: No
CCS: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Staff's Languages: Spanish
Hospital Privileges: Admit Panel

Mina Zarei, M.D.
California Skin Institute
475 S. State College Blvd.
Brea, CA 92821

Dermatology
Tel: (714) 870-7546
Fax: (714) 870-6192

(All Ages)

CCS: No
CCS: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Staff's Languages: Spanish
Hospital Privileges: Admit Panel

Bachar Kurdi, M.D.
11100 Warner Ave., Suite 254
Fountain Valley CA 92708

Endocrinology
Tel: (714) 546-5967
Fax: (714) 546-5970

(18 years and older)
Inpatient Only – Hospial Base

CCS: Yes
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 8am-5pm
Languages: Chinese, Cambodian, Taiwanese, Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center

Aleem A. Syed, M.D.
1211 W. La Palma Ave., Suite 702
Anaheim, CA 92801

Endocrinology
Tel: (714) 533-0300
Fax: (714) 533-0700

(12 years and older)

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M 9am-5pm, T 7am-5pm, W 8am-5pm, Th, F 9am-5pm
Languages: Spanish, Arabic, Hindi, Urdu
Hospital Privileges: Anaheim Global Medical Center

Ashokkumar M. Amin, M.D.
Digestive Disease Center
1711 W. Romneya Dr.
Anaheim CA 92801

Gastroenterology

Tel: (714) 484-1200
Fax: (714) 484-8807

(18 years and older)

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Languages: Hindi, Spanish
Hospital Privileges: Anaheim Regional Medical Center, Garden Grove Hospital & Medical Center, Kindred Hospital –Mirada, St. Jude Medical Center

D. Christopher X. Bui, M.D.
202 N. Euclid St., Suite 201
Santa Ana, CA 92703

Gastroenterology
Tel: (714) 531-3535
Fax: (714) 531-5950

(16 years and older)

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 10am-5pm; Sat 10am-2pm
Provider Languages: French, Vietnamese, Spanish
Staff Languages: Vietnamese, German, French, Spanish, Chinese
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center

Jose L. Pantoja, M.D.
5750 Downey Ave., Suite 202
Lakewood, CA 90712

Gastroenterology
Tel: (562) 634-4939
Fax: (562) 634-5809

(18 years and older)

CCS: NO
CHDP: NO
CPSP: NO

Board Certified: N
Hours: M-F 8am-5pm
Provider's Languages: Spanish
Staff's Languages: Spanish
Hospital Privileges: Lakewood Regional Medical Center, Gardens Regional Hospital and Medical Center

Jason H. Shin, M.D.
12555 Garden Grove Blvd., Suite 206
Garden Grove, CA 92843

Gastroenterology
Tel: (714) 638-8413
Fax: (714) 638-8414

(All Ages)

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Korean
Staff Languages: Korean, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center; South Coast Global Medical Center, Fountain Valley Regional Hospital & Medical Center

David M. Truong, M.D.
10900 Warner Ave., Suite 201
Fountain Valley, CA 92708

Gastroenterology
Tel: (714) 274-9969
Fax: (714) 274-9973

(18 years and older)

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-Th 9am-5pm, F 9am-12pm
Provider Languages: Vietnamese, French
Staff Languages: Vietnamese, Spanish, French
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Jason S. Yip, M.D. | **Gastroenterology** | **(18 years and older)**
OC Gastrocare
408 S. Beach Blvd., Suite 211
Anaheim, CA 92804
Tel: (714) 527-6000
Fax: (714) 527-2371
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am–5pm
Languages: Chinese, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, Anaheim Regional Medical Center, West Anaheim Medical Center

Richard (Dick) M. Yip, M.D. | **Gastroenterology** | **(18 years and older)**
OC Gastrocare
408 S. Beach Blvd., Suite 211
Anaheim, CA 92804
Tel: (714) 527-6000
Fax: (714) 527-2371
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am–5pm
Provider Languages: Chinese
Staff's Languages: Spanish, Chinese
Hospital Privileges: Garden Grove Hospital & Medical Center, Anaheim Regional Medical Center, West Anaheim Medical Center

Sahil Gambhir, M.D. | **General Surgery** | **(All Ages)**
Iqbal Surgical Associates
18225 Brookhurst St, Suite 5
Fountain Valley, CA 92708
Tel: (714) 599-8222
Fax: (714) 599-8223

Board Certified: Y
Hours: M-F 9am-5pm
Staff Languages: Spanish, Vietnamese, Korean
Hospital Privileges: Orange Coast Memorial Medical Center, Foothill Regional Hospital, Fountain Valley Regional Hospital & Medical Center, Chapman Global Medical Center

Richard Guerrero, M.D. | **General Surgery** | **(All Ages)**
11100 Warner Ave., Suite 266
Fountain Valley, CA 92708
Tel: (714) 617-4733
Fax: (714) 617-4748
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages:
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Garden Grove Hospital & Medical Center, Huntington Beach Hospital, Orange Coast Memorial Medical Center, Placentia-Linda Community Hospital, South Coast Global Medical Center

Sami B. Hamamji, M.D. | **General Surgery/Bariatric Surgery** | **(18 years and older)**
1010 W. La Veta Ave., Suite 775
Orange, CA 92868
Tel: (714) 541-5959
Fax: (714) 835-9550
CCS: No
CHDP: No
CPSP: No

Board Certified: Y (General Surgery only)
Hours: M-F 9am-5pm
Provider Languages: Arabic, Spanish, French
Staff Languages: Spanish
Hospital Privileges: St. Joseph Hospital-Orange, Chapman Global Medical Center

Atif Iqbal, M.D. | **General Surgery** | **(17 years and older)**
New Life Surgery | **Bariatric Surgery**
18225 Brookhurst St., Suite 5
Fountain Valley, CA 92708
Tel: (714) 599-8222
Fax: (714) 599-8223
CCS: No
CHDP: No
CPSP: No

Board Certified: Y (General Surgery only)
Hours: M-F 9am-5pm
Provider Languages: Hindhi, Urdu, Punjabi
Staff Languages: Spanish, Hindhi, Urdu, Punjabi
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Chapman Global Medical Center

Connie Lee, M.D. | **General Surgery** | **(All Ages)**
Center for Advanced Breast Care
3791 Katella Ave, Suite 201 | Tel: (562) 206-1312
Los Alamitos, CA 90720 | Fax: (562) 206-1314

Board Certified: Y
Hours: M-F 9am-5pm
Staff's Languages: Spanish
Hospital Privilegs: Long Beach Medical Center, Los Alamitos Medical Center, St. Mary Medical Center

Yasser H. Salem, M.D. | **General Surgery** | **(All Ages)**
8101 Newman Ave., Suite A | Tel: (714) 545-5200
Huntington Beach, CA 92647 | Fax: (714) 545-5250

CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-5pm | **CPSP: No**
Languages: Arabic, Spanish
Hospital Privileges: South Coast Global Medical Center, Fountain Valley Regional Hospital & Medical Center, Huntington Beach Hospital

Christopher E. Salem, D.O. | **Geriatric Medicine** | **(All Ages)**
18021 Sky Park Cr. Bldg 68, Ste G | Tel: (949) 260-0744
Irvine, CA 92614 | Fax: (949) 260-0750

CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 8:30am-5pm | **CPSP: No**
Provider Languages: Arabic
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital, South Coast Global Medical Center, Placentia Linda Hospital, Chapman Global Medical Center

John P. Micha, M.D. | **Gynecology - Assist Only** | **(All Ages)**
Gynecologic Oncology Associates
351 Hospital Rd., Suite 507 | Tel: (949) 642-1361 | **CCS: Yes**
Newport Beach CA 92663 | Fax: (949) 642-1394 | **CHDP: No**
CPSP: No

Hours: M-F 9am-5pm
Board Certified: N
Staff Languages: Spanish
Hospital Privileges: Utilizes Admit Provider

Annemarie T. Nguyen, M.D. | **Gynecology** | **(11 years and older)**
12665 Garden Grove Blvd., Suite 611 | Tel: (714) 539-5225
Garden Grove CA 92843 | Fax: (714) 539-5213

CCS: No
Board Certified: N | **CHDP: No**
Hours: M, T, Th 9am-5pm; F 9am-1pm (closed 1st and 3rd Fri of the month) | **CPSP: Yes**
Provider Languages: Vietnamese
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Garden Grove Hospital & Medical Center, South Coast Global Medical Center

Mark Haddad, H.A. | **Hearing Aid Dispenser** | **(All Ages)**
Sun Coast Hearing Aids
6888 Lincoln Ave., Suite E | Tel: (714) 229-9178 | **CCS: No**
Buena Park, CA 90620 | Fax: (714) 229-9187 | **CHDP: No**
CPSP: No

Hours: M-F 9am-5pm
Provider Languages: Spanish
Staff Languages: Spanish

2nd Address: 7911 Garden Grove Blvd. | Tel: (714) 889-1582
Garden Grove, CA 92841 | Fax: (714) 889-1568
Hours: M-F 9am-5pm; Sat 9am-2pm

Nihal Abdulla, MD | **Hematology/Oncology** | **(18 years and older)**
3851 Katella Avenue, Suite 125
Los Alamitos, CA 90720
Tel: (562) 735-0602
Fax: (562) 490-8590

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8:30am – 5:00pm
Provider Languages: Farsi
Staff's Languages: Spanish, Vietnamese
Hospital Privileges: Los Alamitos Medical Center, Long Beach Memorial Medical Center, College Hospital of Long Beach, St. Mary Hospital Long Beach, Lakewood Regional Medical Center

Arati Rani Chand, M.D. | **Hematology/Oncology** | **(18 years and older)**
The Oncology Intitute of Hope & Innovation
1801 W. Romneya Drive, Suite 103
Anaheim, CA 92801
Tel: (714) 399-0620
Fax: (310) 399-0621

CCS: No
CHDP: No
CPSP: No

Board Certified:Y
Hours: M-F 8:30am – 5:00pm
Provider Languages: Hindhi, Tagalog, Spanish Chinese
Staff Languages: Spanish
Hospital Privileges: Adventist Health White Memorial, Beverly Hospital, East Los Angeles Doctors Hospital, Glendale Adventist Medical Center, Glendale Memorial Hosptial & Health Center, Los Angeles Community Hospital at Norwalk, Monterey Park Hospital, Verdugo Hills Hospital

2nd Address:
11480 Brookshire Ave., Suite 309
Downey, CA 90241
Tel: (562) 869-1201
Fax: (562) 869-1281
Hours: M-F 8:30am-5:00pm
Provider Languages: Portuguese
Staff Languages: Spanish

Mauro J. Janoski, M.D. | **Hematology/Oncology** | **(18 years and older)**
The Oncology Intitute of Hope & Innovation
1801 W. Romneya Drive, Suite 103
Anaheim, CA 92801
Tel: (714) 399-0620
Fax: (310) 399-0621

CCS: No
CHDP: No
CPSP: No

Hours: M-F 8:30am – 5:00pm
Board Certified:Y
Provider Languages: Portuguese
Staff Languages: Spanish
Hospital Privileges: Anaheim Global Medical Center, Foothill Regional Medical Center, Fountain Valley Regional Hospital, Kindred Hospital -Brea, Kindred Hospital-La Mirada & Westminster, Parkview Community Hospital, South Coast Global Medical Center

2nd Address:
11480 Brookshire Ave., Suite 309
Downey, CA 90241
Tel: (562) 869-1201
Fax: (562) 869-1281
Hours: M-F 8:30am-5:00pm
Provider Languages: Portuguese
Staff Languages: Spanish

Haresh S. Jhangiani, M.D. | **Hematology/Oncology** | **(18 years and older)**
Compassionate Cancer Care Medical Group
11180 Warner Ave., Suite 351
Fountain Valley, CA 92708
Hours: M-F 8am-5pm
Tel: (714) 698-0300
Fax: (714) 698-0303

CCS: Yes
CHDP: No
CPSP: No

Board Certified: N
Provider Languages: Indian
Staff Languages: Chinese, Vietnamese, Spanish, Tegalo, Cambodian, Korean, Persian, Russian
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Corona Regional Medical Center

Nelly Awkar-Lazo, M.D. | **Hematology/Oncology** | **(18 years and older)**
The Oncology Institute of Hope and Innovation
1801 W. Romneya Drive, Suite 103 | Tel: (714) 399-0620 | **CCS: No**
Anaheim, CA 92801 | Fax: (310) 399-0621 | **CHDP: No**
CPSP: No

Hours: M-F 8:30am – 5:00pm
Board Certified:Y
Provider Languages: Arabic, French
Staff Languages: Spanish
Hospital Privileges: Anaheim Regional Medical Center, Chapman Global Medical Center, Foothill Regional Medical Center, Fountain Valley Regional Hospital, Garden Grove Hospital & Medical Center, MemorialCare Saddleback Medical Center, Placentia Linda Community Hospital, West Anaheim Medical Center

2nd Address:
11480 Brookshire Ave., Suite 309 | Tel: (562) 869-1201
Downey, CA 90241 | Fax: (562) 869-1281
Hours: M-F 8:30am-5:00pm
Provider Languages: Arabic, French
Staff Languages: Spanish

Omkar Marathe, M.D. | **Hematology/Oncology** | **(18 years and older)**
The Oncology Institute of Hope and Innovation
1801 W. Romneya Drive, Suite 103 | Tel: (714) 399-0620 | **CCS: No**
Anaheim, CA 92801 | Fax: (310) 399-0621 | **CHDP: No**
CPSP: No

Hours: M-F 8:30am – 5:00pm
Board Certified:Y
Hospital Privileges: Lakewood Regional Hospital, Los Alamitos Hospital

Janet Pan, M.D. | **Hematology/Oncology** | **(All Ages)**
Compassionate Cancer Care Medical Group
11180 Warner Ave., Suite 351 | Tel: (714) 698-0300 | **CCS: No**
Fountain Valley, CA 92708 | Fax: (714) 698-0303 | **CHDP: No**
CPSP: No

Hours: M-F 9am-5pm
Board Certified: Y (Hematology & Medical Oncology)
Provider Languages: Chinese, Spanish
Staff Languages: Mandarin, Vietnamese, Spanish, Korean
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Hoag Memorial Hospital Presbyterian

Vu Q. Phan, M.D. | **Hematology/Oncology** | **(18 years and older)**
1760 Termino Ave., Suite 101 | Tel: (562) 735-0602
Long Beach, CA 90804 | Fax: (562) 490-8590
CCS: No
Board Certified: Y (Hematology & Medical Oncology) | **CHDP: No**
Hours: M-F 8:30am-5pm | **CPSP: No**
Provider Languages: Vietnamese
Staff Languages: Cambodian, Spanish, Tagalog
Hospital Privileges: Los Alamitos Medical Center, Orange Coast Memorial Medical Center, St. Mary Medical Center, Long Beach Memorial Medical Center, Lakewood Regional Medical Center,

2nd Address; 3851 Katella Ave., Suite 125 | Tel: (562) 735-0602
Los Alamitos, CA 90720 | Fax: (562) 490-0602
Hours: M-F 8:30am-5pm

Merrill Shum, M.D. | **Hematology/Oncology** | **(18 years and older)**
Cancer and Blood Specialty Clinic
3851 Katella Ave, Suite 125 | Tel: (562) 735-0602 | **CCS: No**
Los Alamitos, CA 90720 | Fax: (562) 490-8590 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5:00pm
Provider Languages: Spanish
Hospital Privileges: Barlow Respiratory Hospital, PIH Hospital – Whittier, Placentia-Linda Community Hospital, Whittier Hospital Medical Center

Balaganesh Gopurala, M.D. | **Hematology/Oncology** | **(18 years and older)**
11480 Brookshire Avenue, Suite 309
Downey, CA 90214
Tel: (562) 869-1201
Fax: (562) 869-1281

CCS: No
CHDP: No
CPSP: No

Board Certified:
Hours: M-F 8:30am -5:00pm
Provider Languages: Telugu
Staff's Languages: Spanish
Hospital Privileges: White Memorial Medical Center, Providence St. Joseph

2nd Address: 11550 Indian Hills Rd. Ste. 330
Mission Hills, Ca 91345
Hours: M-F 8:30am -5:00pm
Tel: (818) 296-9477
Fax: (818)492-1741

Ranjan Sapra, M.D. | **Hematology/Oncology** | **(18 years and older)**
The Oncology Institute of Hope and Innovation | **IN PROCESS**
11100 Warner Ave., Suite 214
Fountain Valley, CA 92708
Tel: (714) 594-7820
Fax: (714) 582-5641

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8:30am -5:00pm
Staff's Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital, South Coast Global Medical Center

2nd Address: 999 N. Tustin Ave. Ste 212
Santa Ana, CA 92705
Hours: M-F 8:30am -5:00pm
Tel: (714) 542-010

Shawn Crum, D.O. | **Infectious Disease** | **(All Ages)**
3851 Katella Ave., Suite 305
Los Alamitos, CA 90720
Tel: (714) 386-9043
Fax: (844) 458-1027

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 7:30am-5pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Foutnian Valley Rergional Hospital, Los Alamitos Medical Center, Kindred Westminster

Pankaj M. Khemka, M.D. | **Infectious Disease** | **(18 years and older)**
1211 W. La Palma Ave., Suite 410
Anaheim, CA 92801
HIV/AIDS Specialist
Tel: (714) 288-8887
Fax: (714) 758-2927

CCS: No
CHDP: No
CPSP: No

Board Certified: Yes
Hours: M-F 9am-5pm
Provider Languages: Hindhi
Staff Languages: Spanish
Hospital Privileges: Orange County Global Medical Center, Anaheim Regional Medical Center, Placentia Linda Hospital, Hoag Hospital

Dalilah Restrepo, MD | **Infectious Disease** | **(All Ages)**
3334 E. Coast Hwy, Suite 655
Corona Del Mar, CA 92625
Tel: (714) 386-9043

Board Certified: Yes
Hours: M-F 8am-5pm
Provider Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital, Kindred Hospital Westminster, Los Alamitos Medical Center

Rokhrsareh Tajrishi, M.D. | **Infectious Disease** | **(All Ages)**
3334 E. Coast Hwy., Suite 570
Corona Del Mar , CA 92625
Tel: (949) 478-2088
Fax:

CCS: No
CHDP: No
CPSP: No

Board Certified: Yes
Hours: M-F 7:30am-5pm
Provider Languages: Farsi
Staff Languages: Spanish
Hospital Privileges: Garden Grove Hosital, Foutnian Valley Rergional Hospital, Los Alamitos Medical Center, Kindred Westminster

Tracy Zivin-Tutela, MD | **Infectious Disease** | **(All Ages)**
11037 Warner Ave, Ste 265
Corona Del Mar, CA 92708
Tel: (714) 386-9043

Board Certified: Yes
Hours: M-F 8am-5pm
Hospital Privileges: Fountain Valley Hospital. Kindred Hospital Westminster, Los Alamitos Medical Center

Melissa Bush, M.D. | **Maternal Fetal Medicine** | **(All Ages)**
Magella Medical Group, Inc.
24411 Health Center Drive, Suite 300
Laguna Hills, CA 92653
Tel: (949) 452-7199
Fax: (855) 834-1617

Board Certified:
Hours: M-F 8am-5pm
Hospital Priveleges: Hoag Memorial Hospital Presbyerian; Long Beach Memorial Medical Center, Saddleback Medical Center

2nd Address:
15785 Laguna Canyon Rd, Suite 360
Irvine, CA 92618
Tel: (949) 788-0079
Fax: (855) 834-1617

3rd Address:
1 Hoag Drive
Newport Beach, CA 92663
Tel: (949) 764-4624
Fax: (855) 834-1617

4th Address:
12401 Washington Blvd., 2nd Floor
Whittier, CA 90602
Tel: (562) 698-0811
Fax: (855) 834-1617

5th Address:
24451 Health Center Drive
Laguna Hills, CA 92653
Tel: (949) 837-4500
Fax: (855) 834-1617

6th Address:
2801 Atlantic Ave
Long Beach, CA 90806
Tel: (562) 933-2000
Fax: (855) 834-1617

7th Address:
2888 Long Beach Blvd., Suite 400
Long Beach, CA 90806
Tel: (562) 997-8510
Fax: (855) 834-1617

8th Address:
361 Hospital Road, Suite 229
Newport Beach, CA 92663
Tel: (714) 547-0900
Fax: (855) 834-1617

Kenneth Kai Hei Chan, M.D. | **Maternal Fetal Medicine** | **(All Ages)**
Magella Medical Group, Inc. | **IN PROCESS**
2888 Long Beach Blvd., Suite 400
Long Beach, CA 90806
Tel: (562) 997-8510
Fax: (562) 997-8520

Board Certified: Y
Hours: M-F 8am-5pm
Hospital Priveleges: Long Beach Memorial Medical Center, Providence Little Company of Mary Medical Center, PHI Whittier

2nd Address:
361 Hospital Road, Suite 229
Newport Beach, CA 92663
Tel: (714) 547-0900
Fax: (855) 834-1617

3rd Address:
24451 Health Center Drive
Laguna Hills, CA 92653
Tel: (949) 837-4500
Fax: (855) 834-1617

Cindy Chau, M.D. | **Maternal Fetal Medicie** | **All Ages**
Magella Medical Group, Inc.
2888 Long Beach Blvd. Suite 400 | Tel: (562) 997-8510
Long Beach, CA 90806 | Fax: (562) 997-8520

CCS: YES
Board Cert: N | **CHDP: NO**
Hours: M-F 8am-5pm | **CPSP: YES**
Staff's Languages: Spanish
Hospital Privileges: Long Beach Memorial Medical Center, Saddleback Memorial Medical Center, Hoag Memorial Hospital Presbyterian, Presbyterian Intercommunity Hospital

2nd Address:
361 Hospital Rd., Suite 229 | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax: (714) 620-3008

3rd Address:
15785 Laguna Canyon Rd., #360 | Tel: (562) 933-2000
Irvine, CA 90806 | Fax: (714) 620-3008

Robert Clifton Day, M.D. | **Maternal Fetal Medicine** | **All Ages**
Magella Medical Group, Inc.
2801 Atlantic Ave | Tel: (562) 933-2000
Long Beach, CA 90806 | Fax: (714) 620-3008

CCS: YES
Board Cert: N | **CHDP: NO**
Hours: M-F 8am-5pm | **CPSP: YES**
Staff's Languages: Spanish
Hospital Privileges: Long Beach Memorial Medical Center

2nd Address:
2888 Long Beach Blvd. Ste. 400 | Tel: (562) 997-8510
Long Beach, CA 90806 | Fax: (562) 997-8520

3rd Address:
1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax (714) 620-3008

Damon I. Masaki, M.D | **Maternal Fetal Medicine** | **All Ages**
Magella Medical Group, Inc.
24411 Health Center Drive, Suite 300 | Tel: (949) 452-7199
Laguna Hills, CA 92653 | Fax: (855) 834-1617

Board Certified:
Hours: M-F 8am-5pm
Hospital Priveleges:

2nd Address:
361 Hospital Road, Suite 229 | Tel: (714) 547-0900
Newport Beach, CA 92663 | Fax: (855) 834-1617

3rd Address:
24451 Health Center Drive | Tel: (949) 837-4500
Laguna Hills, CA 92653 | Fax: (855) 834-1617

4th Address:
1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax: (855) 834-1617

5th Address:
12401 Washington Blvd., 2nd Floor | Tel: (562) 698-0811
Whittier, CA 90602 | Fax: (855) 834-1617

6th Address:
15785 Laguna Canyon Rd, Suite 360 | Tel: (949) 788-0079
Irvine, CA 92618 | Fax: (855) 834-1617

7th Address:
2801 Atlantic Ave | Tel: (562) 933-2000
Long Beach, CA 90806 | Fax: (855) 834-1617

Jennifer Ann McNulty, M.D. | **Maternal & Fetal Medicine** | **All Ages**
Magella Medical Group, Inc. | | **IN PROCESS**
2888 Long Beach Blvd., Suite 400 | Tel: (562) 997-8510
Long Beach, CA 90806 | Fax: (855) 834-1617

Board Certified:
Hours: M-F 8am-5pm
Hospital Privileges: Long Beach Medical Center, Presbyterian Intercommunity Hospital

2nd Address:
12401 Washington Blvd., 2nd Floor | Tel: (562) 698-0811
Whittier, CA 90602 | Fax: (855) 834-1617

3rd Address:
12462 Putnam St., Ste.303 | Tel: (562) 789-5460
Whittier, CA 90602 | Fax: (855) 834-1617

4th Address:
15785 Laguna Canyon Rd, Suite 360 | Tel: (949) 788-0079
Irvine, CA 92618 | Fax: (855) 834-1617

5th Address:
24411 Heathl Ctr Dri. Ste. 300 | Tel: (949) 452-7199
Laguna Hills, CA 92653 | Fax: (855) 834-1617

6th Address:
2801 Atlantic Ave | Tel: (562) 933-2000
Long Beach, CA 90806 | Fax: (855) 834-1617

7th Address:
3330 Lomita Blvd | Tel: (310) 325-9110
Torrance, CA 90505 | Fax: (855) 834-1617

8th Address
361 Hospital Road, Ste 229 | Tel: (714) 547-0900
Newport Beach, CA 92663 | Fax: (855) 834-1617

9th Address
4101 Torrance Blvd. | Tel: (310) 540-7676
Torrence, CA 90503 | Fax: (855) 834-1617

Marlin Dennis Mills, M.D. | **Maternal Fetal Medicine** | **All Ages**
Magella Medical Group, Inc.
361 Hospital Road Ste. 229 | Tel: (714) 547-0900
Newport Beach, CA 92663 | Fax: (855) 834-1617

Board Certified: Y
Hours: M-F 8am-5pm
Hospital Privileges: Long Beach Medical Center, Providence Little Company of Mary Medical Center

2nd Address:
1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax: (855) 834-1617

3rd Address:
15785 Laguna Canyon Rd., Ste. 360 | Tel: (949) 788-0079
Irvine, CA 92618 | Fax: (855) 834-1617

4th Address:
24411 Health Ctr Dr., Ste 300 | Tel: (949) 452-7199
Laguna Hills, CA 92653 | Fax: (855) 834-1617

5th Address:
24451 Health Center Dr. | Tel: (949) 837-4500
Laguna Hills, CA 92653 | Fax: (855) 834-1617

6th Address:
2801 Atlantic Ave | Tel: (562) 933-2000
Long Beach, CA | Fax: (855) 834-1617

Michael Nageotte, M.D. | **Maternal Fetal Medicine** | **All Ages – IN PROCESS**
Magella Medical Group, Inc. | | **CCS: No**
2888 Long Beach Blvd., Suite 400 | Tel: (562) 997-8510 | **CHDP: No**
Long Beach, CA 90806 | Fax: (855) 834-1617 | **CPSP: No**

Board Certified: Y
Hours: M-F 8am-5pm
Staff Languages: Spanish
Hospital Privileges: Long Beach Medical Center, PIH Health Hospital-Whittier

2nd Address:
1 Hoag Drive — Tel: (949) 764-4624
Newport Beach, CA 92663 — Fax: (855) 834-1617

3rd Address:
2801 Atlantic Ave — Tel: (562) 933-2000
Long Beach, CA 90806 — Fax: (855) 834-1617

4th Address:
2865 Atlantic Ave. Suite 110 — Tel: (562) 933-0590
Long Beach,CA 90806 — Fax: (855) 834-1617

5th Address:
15785 Laguna Canyon Rd., Ste. 360 — Tel: (949) 788-0079
Irvine, CA 92618 — Fax: (855) 834-1617

6th Address:
12462 Putnam St., Ste.303 — Tel: (562) 789-5460
Whittier, CA 90602 — Fax: (855) 834-1617

7th Address:
4101 Torrance Blvd. — Tel: (310) 540-7676
Torrance, CA 90503 — Fax: (855) 834-1617

8th Address:
24411 Heathl Ctr Dri. Ste. 300 — Tel: (949) 452-7199
Laguna Hills, CA 92653 — Fax: (855) 834-1617

9th Address:
3330 Lomita Blvd — Tel: (310) 325-9110
Torrance, CA 90505 — Fax: (855) 834-1617

10th Address:
361 Hospital Road, Ste 229 — Tel: (714) 547-0900
Newport Beach, CA 92663 — Fax: (855) 834-1617

11th Address:
23441 Madison St. Suite 290 — Tel: (310) 375-7172
Torrance, CA

Megan Oakes, M.D. | **Maternal Fetal Medicine** | **All Ages**
Magella Medical Group, Inc.
2888 Long Beach Blvd. Suite 400 | Tel: (562) 997-8510 | **CPSP: YES**
Long Beach, CA 90806 | Fax: (562) 997-8520 | **CHDP: NO**
Board Certified: N | | **CPSP: YES**
Hours: M-F 8:00am-5pm
Hospital Privileges: Long Beach Memorial Medical Center, Providence Little Company of Mary Medical Center Torrance, Presbyterian Interncommunity Hospital

2nd Address:
12462 Putnam St., Ste 303 — Tel: (562)789-5460
Whittier, CA 90602 — Fax: (562)789-4374

Emily Seet, M.D. **Maternal Fetal Medicine** **(All Ages)**
Magella Medical Group, Inc. **IN PROCESS**
2888 Long Beach Blvd., Suite 400 Tel: (562) 997-8510
Long Beach, CA 90806 Fax: (855) 834-1617

Board Certified: Yes
Hours: M-F 8am-5pm
Hospital Priveleges: Long Beach Medical Center, Presbyterian Intercommunity Hospital

2nd Address:
23441 Madison Street, Blvd 8 Ste.29 Tel: (310) 375-7172
Torrance, CA 90505 Fax: (855) 834-1617

3rd Address:
12401 Washington Blvd., 2nd Floor Tel: (562) 698-0811
Whittier, CA 90602 Fax: (855) 834-1617

4th Address:
12462 Putnam St., Ste.303 Tel: (562) 789-5460
Whittier, CA 90602 Fax: (855) 834-1617

5th Address:
15785 Laguna Canyon Rd, Suite 360 Tel: (949) 788-0079
Irvine, CA 92618 Fax: (855) 834-1617

6th Address:
24451 Health Center Drive Tel: (949) 837-4500
Laguna Hills, CA 92653 Fax: (855) 834-1617

7th Address:
2801 Atlantic Ave Tel: (562) 933-2000
Long Beach, CA 90806 Fax: (855) 834-1617

8th Address:
3380 Lomita Blvd Tel: (310) 325-9110
Los Angeles, CA Fax: (855) 834-1617

9th Address:
361 Hospital Road, Suite 229 Tel: (714) 547-0900
Newport Beach, CA 92663 Fax: (855) 834-1617

10th Address:
4101 Torrannce Blvd. Tel: (310) 540-7676
Torrance, CA 90503 Fax: (855) 834-1617

Vineet Shrivastava, M.D. | **Maternal Fetal Medicine** | **(All Ages)**
Magella Medical Group, Inc. | | **IN PROCESS**
361 Hospital Road, Suite 229 | Tel: (714) 547-0900
Newport Beach, CA 92663 | Fax: (855) 834-1617

Board Certified: Yes
Hours: M-F 8am-5pm
Hospital Priveleges: Admit Panel

2nd Address:
2888 Long Beach Blvd., Suite 400 | Tel: (562) 997-8510
Long Beach, CA 90806 | Fax: (855) 834-1617

3rd Address:
1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax: (855) 834-1617

4th Address:
12462 Putnam St., Ste. 3030 | Tel: (562)789-5460
Whittier, CA 90602 | Fax: (855) 834-1617

5th Address:
15785 Laguna Canyon Rd, Suite 360 | Tel: (949) 788-0079
Irvine, CA 92618 | Fax: (855) 834-1617

6th Address:
23441 Madison Street, Blvd 8 Ste.29 | Tel: (310) 375-7172
Torrance, CA 90505 | Fax: (855) 834-1617

7th Address:
24411 Health Ctr Dr., Ste 300 | Tel: (949) 452-7199
Laguna Hills, CA 92653 | Fax: (855) 834-1617

8th Address:
24451 Health Center Drive | Tel: (949) 837-4500
Laguna Hills, CA 92653 | Fax: (855) 834-1617

9th Address:
2801 Atlantic Avenue | Tel: (562) 933-2000
Long Beach, CA 90806 | Fax: (855) 834-1617

10th Address:
3330 Lomita Blvd | Tel: (310) 325-9110
Torrance, CA 90505 | Fax: (855) 834-1617

Xuanto Leduc, M.D. | **Medical Genetics** | **(0-18 years)**
Leduc Medical Group, Inc.
10900 Warner Ave. Suite 122 | Tel: (714) 540-0105
Fountain Valley, CA 92708 | Fax: (714) 540-6727

Board Certified: Y | **CHDP: NO**
Hours: M-F 9am-5pm | **CPSP: NO**
Provider's Languages: Vietamese | **CPSP: NO**
Staff's Languages: Spanish, Vietamese
Hospital Privileges: Children's Hospital of Los Angeles

Peyman Salimi-Tari, M.D. | **Medical Oncology** | **(All Ages)**
Compassionate Cancer Care Medical Group, Inc.
18111 Brookhurst St., Suite 6100 | Tel: (714) 698-0300 | **CCS: Yes**
Fountain Valley, CA 92708 | Fax: (714) 698-0303 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M-F 9am-5pm
Provider's Languages: Farsi
Staff's Languages: Chinese, Vietnamese, Tagalog, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Hoag Memorial Hospital Presbyterian, Los Alamitos Medical Center

CHOC Pediatric Subspecialty Faculty | **Neonatology** | **FACILITY-BASED**
1201 W. LaVeta Ave.
Orange, CA 92868
Tel: (714) 509-3096
Fax: (714) 509-7800

Hospital Privileges: Children's Hospital of Orange County
Ragnar N. Amlie, M.D.
Daryoush Bassiri, M.D.
Heather Carriedo, M.D.
David C. Kim, M.D.
Anthony D. Liu, M.D.
Victoria Nwafor-Anene, M.D.
Dilipkumar Patel, M.D.
Daniel D. Saesim, M.D.

Jacob Sweidan, M.D. | **Neonatology** | **(0-18 years)**
Pediatric & Neonatology Medical Group of Orange County, Inc.
12665 Garden Grove Blvd., Suite 713
Garden Grove, CA 92843
Tel: (714) 537-6595 or (714) 537-7500
Fax: (714) 537-2176

Board Certified: N
Hours: M, T, Th 9am-5pm; W, F 9am-1pm
CCS: Yes
Languages: Spanish, Romanian
Hospital Privileges: Garden Grove Hospital & Medical Center, South Coast Global Medical Center, Fountain Valley Regional Hospital & Medical Center, Orange County Global Medical Center, Orange Coast Memorial Medical Center; Children's Hospital of Orange County, Hoag Memorial Hospital Presbyterian, UCI Medical Center

2nd Address: **StrongKids Medical Group, Inc.**
2222 S. Main St.
Santa Ana, CA 92704
Hours: M-F 9am-5pm; Sat 10am-3pm
Tel: (714) 436-9999 or (714) 542-1331
Fax: (714) 542-4758

3rd Address: **StrongKids Medical Group, Inc.**
1491 E. La Palma Ave., Suite B
Anaheim, CA 92805
Hours: M-F 9am-5pm; Sat 10am-3pm
Tel: (714) 535-3330
Fax: (714) 535-4332

Zavier Ahmed, M.D. | **Nephrology** | **(18 years and older)**
11180 Warner Ave., Suite H463
Fountain Valley, CA 92708
Hours: M-F 9:00am – 5:00pm
Tel: (714) 241-9200
Fax: (714) 241-9109
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Provider Languages: Urdu
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital, Garden Grove Hospital, Huintington Beach Hospital, South Coast Global Medical Center

Steve Bui, M.D. | **Nephrology** | **(All Ages)**
Orange County Renal Medical Group, Inc.
12665 Garden Grove Blvd., Suite 211
Garden Grove, CA 92843
Tel: (714) 636-2890
Fax: (714) 636-2909
CCS: No
CHDP: No
CPSP: No

Hours: M-F 9am-5pm
Provider Languages: Vietnamese, Spanish
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, St. Joseph Hospital-Orange, Anaheim Regional Medical Center,

Alan Cantillep, M.D. | **Nephrology** | **All Ages**
Balboa Nephrology Medical Group, Inc.
11100 Warner Avenue Suite 218
Fountain Valley, CA 92708
Tel: (714) 641-9696
Fax: (714) 641-1211
CCS:No
CHDP:No
CPSP: No

Hours: M-F 9am-5pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital, Garden Grove Hospital, Hoag Hospital-Irvine, Hunting Beach Hospital, Kindred Hospital of Santa Ana, Kindred Hospital of Wesminster, Orange Coast Memorial Medical Center, Orange County Global Medical Center, Providence St. Joseph Hospital, Saddleback Memorial Medical Center, South Coast Global Medical Center.

An Quoc Dang, M.D. | **Nephrology** | **(16 years and older)**
13872 Harbor Blvd., Suite 1C
Garden Grove, CA 92843
Tel: (714) 531-5791
Fax: (657) 600-8560

CCS: Yes
CHDP: No
CPSP: No

Board Certified: N
Hours: M, T, Th, F 10am-6pm; W 4pm-6pm; Sat 10am-3pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Adarsh Daswani, M.D. | **Nephrology** | **(18 years and older)**
Preferred Nephrology Medical Group, Inc.
3300 E. South St., Suite 110
Long Beach, CA 90805
Tel: (562) 630-7279
Fax: (562) 630-8828

CSS: No
CHDP: Yes
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Staff's Languages: Spanish
Hospital Privileges: Garden Grove Hospital, Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Long Beach Memorial Medical Center, Lakewood Regional Medical Center, Los Alamitos Medical Center, Promise Hospital of East Los Angeles, Anaheim Regional Medical Center, Kindred Hospital-Westminster, Kindred Hospital-La Mirada, Gardens Regional Hospital Medical Center

2nd Address:
12555 Garden Grove Blvd., Suite 305
Garden Grove, CA 92843
Tel: (562) 630-7279
Fax: (562) 630-8828
Hours: M 8am-1pm; T 1pm-5pm; Th 8am-12pm
Staff Languages: Spanish

George G. Hon, M.D. | **Nephrology** | **(18 years and older)**
3610 Long Beach Blvd., Suite 201
Long Beach, CA 90807
Tel: (562) 297-4120
Fax: (562) 297-4008

Board Certified: Y
Hours: M-F 8:30am-5pm
Provider Languages: Mandarin, Taiwanese
Staff Languages: Spanish
Hospital Privileges: Long Beach Memorial Medical Center, St. Francis Medical Center, Promise Hospital of Los Angeles, Suburban Medical Center, Lakewood Regional Medical Center

CCS: Yes
CHDP: No
CPSP: No

Afsaneh Haftbaradran-Mohammadi, M.D. | **Nephrology** | **(18 years and older)**
Pacific Renal Care Medical Corp.
11180 Warner Avenue, Suite 463
Fountain Valley, CA 92708
Tel: (714) 241-9200
Fax: (714) 241-9109

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 9am – 5pm
Provider Languages: Farsi
Staff's Languages: Spanish
Hospital Privileges: South coast Global Medical Center, Chapman Global Medical Center, Foothill Regional Medical Center

Joginder Jodhka, M.D. | **Nephrology** | **(18 years and older)**
Pacific Renal Care Medical Corp.
11180 Warner Ave., Suite 463
Fountain Valley, CA 92708
Tel: (714) 241-9200
Fax: (714) 241-9109

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Hindhi, Punjabi
Languages: Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, South Coast Global Medical Center, Orange County Global Medical Center, Fountain Valley Regional Hospital & Medical Center

Tarun Marwaha, M.D. | **Nephrology** | **(18 years and older)**
Pacific Renal Care Medical Corp.
11180 Warner Ave., Suite 463 | Tel: (714) 241-9200 | **CCS: Yes**
Fountain Valley, CA 92708 | Fax: (714) 241-9109 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Hindi, Punjabi, Spanish
Staff Languages: Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, Chapman Global Medical Center, South Coast Global Medical Center, HealthSouth Rehab Center, Hoag Memorial Hospital Presbyterian, Huntington Beach Hospital, Kindred Hospital-Westminster, Kindred Hospital-Santa Ana, Orange Coast Memorial Medical Center, Orange County Global Medical Center, Newport Specialty Hospital

Alexander J. Sweidan, M.D. | **Neurocritical Care** | **(16 years and older)**
2222 S. Main St. | Tel: (714) 537-7500
Santa Ana, CA 92707 | Fax: (714) 537-2176

CCS: Yes
Provider Languages: Romanian, Polish, Spanish | **CHDP: No**
Staff Languages: Spanish, Vietnamese | **CPSP: No**
Hours: M-F 9:00am – 5:00pm; Sat 10:00am – 1:00pm
Hospital Privileges: Hoag Memorial Hospital Presbyterian, Fountain Valley Regional Hospital

2nd Address: 1491 E. La Palma Ave., Suite B | Tel: (714) 535-3330
Anaheim, CA 92805 | Fax: (714) 535-4332
Hours: M-F 9:00am – 5:00pm; Sat 9:00am – 1:00pm

3rd Address: 136 Broadway | Tel: (949) 873-5537
Costa Mesa, CA 92627 | Fsx: (949) 873-5625
Hours: M-F 9:00am – 6:00pm

Askash Bodhit, MD | **Neurology** | **(18 years and older)**
Wled Wazni, MD Medical Corporation
1050 Linden Ave, 2nd Floor | Tel: (562) 491-9270 | **CCS: NO**
Long Beach, CA 90813 | Fax: (562) 491-7985 | **CHDP: NO**
CPSP: NO

Board Certified: No
Hours: M-F 8:30am-5pm
Provider Languages: Hindi, Gujarati
Staff Languages: Spanish

Tim Lai, M.D. | **Neurology** | **(16 years and older)**
OC Neuromuscular & Neurology Center | Tel: (714) 486-2521 | **CCS: No**
1110 Warner Avenue, Suite 152 | Fax: (714) 486-2613 | **CHDP: No**
Fountain Valley, CA 92708 | **CPSP: No**

Board Certified: Y
Hours: M-F 9am -6pm
Provider Languages: Vietnamese
Staff's Languages: Vietnamese

Christina Nguyen, M.D. | **Neurology** | **(All Ages)**
9904 Talbert Avenue, Suite 204 | Tel: (714) 378-5062 | **CCS: No**
Fountain Valley, CA 92708 | Fax: (714) 378-5061 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am – 5pm; Sat 9am – 5pm
Provider Languages: Vietnamese
Staff's Languages: Vietnamese, Spanich
Hospital Privileges: Orange Coast Memorial Medical Center

James J. Park, D.O. | **Neurology** | **(All Ages)**
Neurological Medical Group of Orange County
11100 Warner Ave., Suite 256 | Tel: (714) 979-1344 | **CCS: No**
Fountain Valley, CA 92708 | Fax: (714) 979-1356 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Langugaes: Korean
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Zhanna Rapoport, M.D. | **Neurology** | **(18 years and older)**
Zhanna Rapoport, M.D., Inc. | **CLOSED PANEL**
24953 Paseo De Valencia, Suite 8A | Tel: (949) 892-3353
Laguna Hills, CA, 92653 | Fax: (949) 272-0036
CCS: No
Board Certified: N | **CHDP: No**
Hours: M, T, W, F 9am-4pm | **CPSP: No**
Provider Langugaes: Russian
Staff Languages: Spanish
Hospital Privileges: Chapman Global Medical Center, Orange County Global Medical Center

Kong Truong, M.D. | **Neurology** | **(All Ages)**
9940 Talbert Avenue, Suite 100 | Tel: (714) 378-5062
Fountain Valley, CA 92708 | Fax: (714) 378-5061 | **CCS: No**
Hours: M-F 9:00 am – 5pm | **CHDP: No**
CPSP: No

Board Certified: Y
Provider's Languages: Vietnamese
Staff's Languages: Spanish, Vietnamese
Hospital Privileges: Orange Coast Memorial Medical Center

The Truong Neuroscience Institute, Inc. | **Neurology** | **(18 years and older)**
9940 Talbert Ave., Suite 100 | Tel: (714) 378-5062
Fountain Valley, CA 92708 | Fax: (714) 378-5061
CCS: No
Hours: M-Sat 9am-5:30pm | **CHDP: No**
Staff Languages: German, Spanish, Tagalog, Hindhi, Vietnamese | **CPSP: No**

Mayank S. Pathak, M.D.
Board Certified: Y
Provider Languages: Hindhi
Hours: M-F 9am-5pm; Sat 9am-4pm
Hospital Privileges: Orange Coast Memorial Medical Center, St. Joseph Hospital-Orange

Daniel D. Truong, M.D.
Board Certified: Y
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

2nd Address:

Daniel D. Truong, M.D.
24411 Health Center Dr., Suite 460 | Tel: (714) 378-5062 | **CCS: No**
Laguna Hills, CA 92653 | Fax: (714) 378-5061 | **CHDP: No**
CPSP: No

Orange County Brain & Spine | **Neurological Surgery** | **(All Ages)**
18035 Brookhurst Street, Suite 1700 | Tel: (714) 433-2000
Fountain Valley, CA 92708 | Fax: (714) 433-2901
CCS: Yes
Hours: M-F 9am-5pm | **CHDP: No**
Staff Language: Vietnamese, Spanish | **CPSP: No**

Tien T. Nguyen, M.D.
Board Certified: Y
Provider Languages: Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Garden Grove Hospital & Medical Center, Long Beach Memorial Medical Center, Orange Coast Memorial Medical Center

Minh Q. Tran, M.D. | **Neurological Surgery** | **(16 years and older)**
14501 Magnolia Ave., Suite 102
Westminster, CA 92683
Tel: (714) 901-0100
Fax: (714) 901-6700

CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M, T, W, F 10am-5pm
Provider Languages: Vietnamese
Staff Language: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Mission Hospital Regional Medical Center

Melissa Bush, M.D. | **Obstetrics & Gynecology** | **(All Ages)**
Magella Medical Group, Inc.
24411 Health Center Drive, Suite 300
Laguna Hills, CA 92653
Tel: (949) 452-7199
Fax: (855) 834-1617

Board Certified:
Hours: M-F 8am-5pm
Hospital Priveleges: Hoag Memorial Hospital Presbyerian; Long Beach Memorial Medical Center, Orange Coast Memorial Medical Center, Saddleback Medical Center

2nd Address:
15785 Laguna Canyon Rd, Suite 360
Irvine, CA 92618
Tel: (949) 788-0079
Fax: (855) 834-1617

3rd Address:
1 Hoag Drive
Newport Beach, CA 92663
Tel: (949) 764-4624
Fax: (855) 834-1617

4th Address:
12401 Washington Blvd., 2nd Floor
Whittier, CA 90602
Tel: (562) 698-0811
Fax: (855) 834-1617

5th Address:
24451 Health Center Drive
Laguna Hills, CA 92653
Tel: (949) 837-4500
Fax: (855) 834-1617

6th Address:
2801 Atlantic Ave
Long Beach, CA 90806
Tel: (562) 933-2000
Fax: (855) 834-1617

7th Address:
2888 Long Beach Blvd., Suite 400
Long Beach, CA 90806
Tel: (562) 997-8510
Fax: (855) 834-1617

8th Address:
361 Hospital Road, Suite 229
Newport Beach, CA 92663
Tel: (714) 547-0900
Fax: (855) 834-1617

Alan Dang, M.D. | **Obstetrics & Gynecology** | **(All Ages)**
2621 S. Bristol St., Suite 300
Santa Ana,CA 92704
Tel: (714) 540-7720
Fax: (714) 540-5690

Board Certified:
Hours: M – F 9am – 5pm
Provider Languages: Vietmese, Spanish
Staff Languages: Spanish
Hospital Privileges: South Coast Global Medical Center, Orange Coast Memorial Medical Center, Fountain Valley Regional Hospital

Robert Clifton Day, M.D. | **Obstetrics & Gynecology** | **All Ages**
Magella Medical Group, Inc.
2801 Atlantic Ave | Tel: (562) 933-2000
Long Beach, CA 90806 | Fax: (714) 620-3008

CCS: YES
CHDP: NO
CPSP: YES

Board Cert: Y
Hours: M-F 8am-5pm
Staff's Languages: Spanish
Hospital Privileges: Long Beach Memorial Medical Center

2nd Address:
2888 Long Beach Blvd. Ste. 400 | Tel: (562) 997-8510
Long Beach, CA 90806 | Fax: (562) 997-8520

3rd Address:

1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax (714) 620-3008

Ebrahim Duel, M.D. | **Obstetrics & Gynecology** | **(All Ages)**
301 N. Main St. | Tel: (714) 547-6641
Santa Ana, CA 92701 | Fax: (714) 541-8161

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5:30pm
Provider Languages: Farsi, Spanish
Staff Languages: Farsi, Spanish
Hospital Privileges: South Coast Global Medical Center, Orange County Global Medical Center

Amin Fawwaz, MD | **Obstetrics & Gynecology** | **(All Ages)**
1110 W. La Palma Avenue, Suite 7 | Tel: (714) 956-9101 | **CCS: No**
Anaheim, CA 92801 | Fax: (714) 956-1012 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M – F 9am – 6pm
Provider Languages: Arabic, Spanish
Staff's Languages: Spanish
Hospital Privileges: Anaheim Regional Medical Center, Western Medical Center-Anaheim, Garden Grove Hospital & Medical Center

Mehrdad Forghani-Arani, D.O. | **Obstetrics & Gynecology** | **(12yrs and older)**
12665 Garden Grove Blvd., Suite 601 | Tel: (714) 537-1387
Garden Grove CA 92843 | Fax: (714) 537-0917

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5pm
Provider Languages: Farsi, Spanish
Staff Languages: Farsi, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, South Coast Global Medical Center, Fountain Valley Regional Hospital & Medical Center

2nd Address:
1515 N. Broadway | Tel: (714) 542-3500
Santa Ana, CA 92706 | Fax: (714) 542-3157
Hours: M-F 8:30am-5pm
Staff Languages: Farsi, Spanish

3rd Address:
1720 W. Ball Rd, Suite 2 | Tel: (714) 533-4822
Anaheim, CA 92804 | Fax: (714) 533-4427

Robert Corey Johnston, M.D. | **Obstetrics & Gynecology** | **All Ages**
Magella Medical Group, Inc. | **IN PROCESS**
2888 Long Beach Blvd., Suite 400 | Tel: (562) 997-8510 | **CCS: No**
Long Beach, CA 90806 | Fax: (562) 997-8520 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Jaime Ludmir, M.D. | **Obstetrics & Gynecology** | **(All Ages)**
2810 S Bristol St.
Santa Ana CA 92704
Tel: (714) 754-7799
Fax: (714) 754-5484

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-Th 9am-7pm; F 9am-1pm
Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, South Coast Global Medical Center

Damon I. Masaki, M.D | **Obstetrics & Gynecology** | **All Ages**
Magella Medical Group, Inc.
24411 Health Center Drive, Suite 300
Laguna Hills, CA 92653
Tel: (949) 452-7199
Fax: (855) 834-1617

Board Certified:
Hours: M-F 8am-5pm
Hospital Priveleges:

2nd Address:
361 Hospital Road, Suite 229
Newport Beach, CA 92663
Tel: (714) 547-0900
Fax: (855) 834-1617

3rd Address:
24451 Health Center Drive
Laguna Hills, CA 92653
Tel: (949) 837-4500
Fax: (855) 834-1617

4th Address:
1 Hoag Drive
Newport Beach, CA 92663
Tel: (949) 764-4624
Fax: (855) 834-1617

5th Address:
12401 Washington Blvd., 2nd Floor
Whittier, CA 90602
Tel: (562) 698-0811
Fax: (855) 834-1617

6th Address:
15785 Laguna Canyon Rd, Suite 360
Irvine, CA 92618
Tel: (949) 788-0079
Fax: (855) 834-1617

7th Address:
2801 Atlantic Ave
Long Beach, CA 90806
Tel: (562) 933-2000
Fax: (855) 834-1617

Marlin Dennis Mills, M.D. | **Obstetrics & Gynecology** | **All Ages**
Magella Medical Group, Inc.
361 Hospital Road Ste. 229 | Tel: (714) 547-0900
Newport Beach, CA 92663 | Fax: (855) 834-1617

Board Certified: Y
Hours: M-F 8am-5pm
Hospital Privileges: Long Beach Medical Center, Providence Little Company of Mary Medical Center

2nd Address:
1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax: (855) 834-1617

3rd Address:
15785 Laguna Canyon Rd., Ste. 360 | Tel: (949) 788-0079
Irvine, CA 92618 | Fax: (855) 834-1617

4th Address:
24411 Health Ctr Dr., Ste 300 | Tel: (949) 452-7199
Laguna Hills, CA 92653 | Fax: (855) 834-1617

5th Address:
24451 Health Center Dr. | Tel: (949) 837-4500
Laguna Hills, CA 92653 | Fax: (855) 834-1617

6th Address:
2801 Atlantic Ave | Tel: (562) 933-2000
Long Beach, CA | Fax: (855) 834-1617

Michael Nageotte, M.D. | **Obstetrics & Gynecology** | **All Ages – IN PROCESS**
Magella Medical Group, Inc. | **CCS: No**
2888 Long Beach Blvd., Suite 400 | Tel: (562) 997-8510 | **CHDP: No**
Long Beach, CA 90806 | Fax: (855) 834-1617 | **CPSP: No**

Board Certified: Y
Hours: M-F 8am-5pm
Staff Languages: Spanish
Hospital Privileges: Long Beach Medical Center, PIH Health Hospital-Whittier

2nd Address:
1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax: (855) 834-1617

3rd Address:
2801 Atlantic Ave | Tel: (562) 933-2000
Long Beach, CA 90806 | Fax: (855) 834-1617

4th Address:
2865 Atlantic Ave. Suite 110 | Tel: (562) 933-0590
Long Beach,CA 90806 | Fax: (855) 834-1617

5th Address:
15785 Laguna Canyon Rd., Ste. 360 | Tel: (949) 788-0079
Irvine, CA 92618 | Fax: (855) 834-1617

6th Address:
12462 Putnam St., Ste.303 | Tel: (562) 789-5460
Whittier, CA 90602 | Fax: (855) 834-1617

7th Address:
4101 Torrance Blvd. | Tel: (310) 540-7676
Torrance, CA 90503 | Fax: (855) 834-1617

8th Address:
24411 Heathl Ctr Dri. Ste. 300 | Tel: (949) 452-7199
Laguna Hills, CA 92653 | Fax: (855) 834-1617

9th Address:
3330 Lomita Blvd | Tel: (310) 325-9110
Torrance, CA 90505 | Fax: (855) 834-1617

10th Address:
361 Hospital Road, Ste 229 | Tel: (714) 547-0900
Newport Beach, CA 92663 | Fax: (855) 834-1617

11th Address:
23441 Madison St. Suite 290 | Tel: (310) 375-7172
Torrance, CA

Phu T. Nguyen, D.O. | **Obstetrics & Gynecology** | **(13 years and older)**
Garden Grove Women's Health Specialists
12555 Garden Grove Blvd., Suite 301 | Tel: (714) 741-0501 | **CCS: No**
Garden Grove CA 92843 | Fax: (775) 587-3506 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center

John L. Pinches, O.D. | **Obstetrics & Gynecology** | **(All Ages)**
Los Alamitos OB-GYN Medical Group, Inc.
8615 Knott Ave., Suite 5 | Tel: (562) 596-5566 | **CCS: No**
Buena Park, CA 90620 | Fax: (562) 596-6506 | **CHDP: No**

Board Certified: N | **CPSP: No**
Hours: M, F 8am-12pm; T, Th 1pm-5pm
Provider Languages: Spanish
Staff Languages: Spanish,Tagalog
Hospital Privileges: St. Mary Medical Center, La Palma Intercommunity Hospital, Los Alamitos Medical Center, West Anaheim Medical Center

2nd Address:
12321 Carson St. Suite 1 | Tel: (562) 860-9660
Hawaiian Gardens ,CA 90716 | Fax: (562) 860-8613
Hours: M 1:30pm-5pm; W 8am-12pm
Staff Languages: Spanish

Emily Seet, M.D. **Obstetrics & Gynecology** **(All Ages)**
Magella Medical Group, Inc.
2888 Long Beach Blvd., Suite 400 Tel: (562) 997-8510
Long Beach, CA 90806 Fax: (855) 834-1617

Board Certified: Yes
Hours: M-F 8am-5pm
Hospital Priveleges: Long Beach Medical Center, Presbyterian Intercommunity Hospital

2nd Address:
23441 Madison Street, Blvd 8 Ste.29 Tel: (310) 375-7172
Torrance, CA 90505 Fax: (855) 834-1617

3rd Address:
12401 Washington Blvd., 2nd Floor Tel: (562) 698-0811
Whittier, CA 90602 Fax: (855) 834-1617

4th Address:
12462 Putnam St., Ste.303 Tel: (562) 789-5460
Whittier, CA 90602 Fax: (855) 834-1617

5th Address:
15785 Laguna Canyon Rd, Suite 360 Tel: (949) 788-0079
Irvine, CA 92618 Fax: (855) 834-1617

6th Address:
24451 Health Center Drive Tel: (949) 837-4500
Laguna Hills, CA 92653 Fax: (855) 834-1617

7th Address:
2801 Atlantic Ave Tel: (562) 933-2000
Long Beach, CA 90806 Fax: (855) 834-1617

8th Address:
3380 Lomita Blvd Tel: (310) 325-9110
Los Angeles, CA Fax: (855) 834-1617

9th Address:
361 Hospital Road, Suite 229 Tel: (714) 547-0900
Newport Beach, CA 92663 Fax: (855) 834-1617

10th Address:
4101 Torrannce Blvd. Tel: (310) 540-7676
Torrance, CA 90503 Fax: (855) 834-1617

Vineet Shrivastava, M.D. | **Obstetrics & Gynecology** | **(All Ages)**
Magella Medical Group, Inc. | | **IN PROCESS**
361 Hospital Road, Suite 229 | Tel: (714) 547-0900
Newport Beach, CA 92663 | Fax: (855) 834-1617

Board Certified: Yes
Hours: M-F 8am-5pm
Hospital Priveleges: Admit Panel

2nd Address:
2888 Long Beach Blvd., Suite 400 | Tel: (562) 997-8510
Long Beach, CA 90806 | Fax: (855) 834-1617

3rd Address:
1 Hoag Drive | Tel: (949) 764-4624
Newport Beach, CA 92663 | Fax: (855) 834-1617

4th Address:
12462 Putnam St., Ste. 3030 | Tel: (562)789-5460
Whittier, CA 90602 | Fax: (855) 834-1617

5th Address:
15785 Laguna Canyon Rd, Suite 360 | Tel: (949) 788-0079
Irvine, CA 92618 | Fax: (855) 834-1617

6th Address:
23441 Madison Street, Blvd 8 Ste.29 | Tel: (310) 375-7172
Torrance, CA 90505 | Fax: (855) 834-1617

7th Address:
24411 Health Ctr Dr., Ste 300 | Tel: (949) 452-7199
Laguna Hills, CA 92653 | Fax: (855) 834-1617

8th Address:
24451 Health Center Drive | Tel: (949) 837-4500
Laguna Hills, CA 92653 | Fax: (855) 834-1617

9th Address:
2801 Atlantic Avenue | Tel: (562) 933-2000
Long Beach, CA 90806 | Fax: (855) 834-1617

10th Address:
3330 Lomita Blvd | Tel: (310) 325-9110
Torrance, CA 90505 | Fax: (855) 834-1617

Bryan H. Tran, M.D. | **Obstetrics & Gynecology** | **(12 years and older)**
Pacific Coast OB/Gyn | | **IN PROCESS**
27800 Medical Center Rd., Suite 230 | Tel: (949) 347-6777 | **CCS: No**
Mission Viejo, CA 92691 | Fax: (949) 489-3158 | **CHDP: No**
CPSP: No

Board Certified: Yes
Hospital Privileges: Admit Panel
Hours: M-F 9am-5pm
Staff's Languages: Spanish, Vietnamese

Tiffany U. Tran, M.D. | **Obstetrics & Gynecology** | **(12 years and older)**
Pacific Coast OB/Gyn
27800 Medical Center Rd., Suite 230 | Tel: (949) 347-6777 | **CCS: No**
Mission Viejo, CA 92691 | Fax: (949) 489-3158 | **CHDP: No**
CPSP: No

Board Certified: Yes
Hospital Privileges: Mission Hospital, Saddleback Memorial Medical Center
Hours: M-F 9am-5pm
Staff's Languages: Spanish, Vietnamese

Pamela Miel, M.D. — **Oncology**
The Oncology Institute of Hope & Innovation — **(18 years and older)**
11100 Warner Ave., Suite 214 — Tel: (714) 598-7420 — **CCS: No**
Fountain Valley, CA 92708 — Fax: (714) 584-5641 — **CHDP: No**
CPSP: No

Board Certified: Yes
Hospital Privileges: Foothill Regional Medical Center, Fountain Valley Regional Hospital
Hours: M-F 8:30am-5pm
Provider Languages: Tagalog
Staff's Languages: Spanish

2nd Address: 999 N. Tustin Ave., Suite 212 — Tel: (714) 542-0102
Santa Ana, CA 92705 — Fax: (657) 229-6879
Hours: M-F 8:30am-5pm

Jessica M. Boeckmann, M.D. — **Ophthalmology** — **(All Ages)**
Retina Institute of California
500 S. Anaheim Hills Rd., Suite 240 — Tel: (714) 921-0232 — **CCS: No**
Anaheim, CA 92807 — Fax: (714) 921-0535 — **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Staff's Languages:
Hospital Privileges: San Gabriel Ambulatory Surgery Center, St. Mary Medical Center

2nd Address: 14642 Newport Ave., Suite 210 — Tel: (714) 884-3961
Tustin, CA 92780 — Fax: (714) 884-3458
Hours: M-F 8am-5pm

Luis A. Chanes, M.D. — **Ophthalmology** — **(All Ages)**
Eye Associates of Orange County
2621 S. Bristol St., Suite 205 — Tel: (714) 557-5777 — **CCS: Yes**
Santa Ana CA 92704 — Fax: (714) 557-7710 — **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Spanish
Staff Languages: Spanish, Mandarin
Hospital Privileges: South Coast Global Medical Center, St. Joseph Hospital-Orange, Orange County Global Medical Center

2nd Address: 27871 Medical Center Rd., Suite 120 — Tel: (949) 364-6688
Mission Viejo, CA 92691 — Fax: (949) 364-6689
Hours: M-F 8am-5pm
Staff Languages: Spanish

Tom S. Chang, M.D. — **Ophthalmology** — **(All Ages)**
Retina Institute of California — **Retinology**
2240 N. Harbor Blvd., Suite 210 — Tel: (714) 278-1834 — **CCS: No**
Fullerton, CA 92835 — Fax: (714) 278-1839 — **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Provider's Languages: Cantonese, Mandarin
Staff's Languages: Spanish, Armenian, Cantonese, Mandarin
Hospital Privileges: San Gabriel Valley Medical Center, San Gabriel Ambulatory Surgery Center

2nd Address: 111800 Warner Ave., Suite 163 — Tel: (714) 751-1188
Fountain Valley, CA 92708 — Fax: (714) 751-2403
Hours: M-F 8am-5pm

3rd Address: 14501 Magnolia Street, Ste 103 — Tel: (800) 898-2020
Westminster, CA 92683 — Fax: (626) 574-7188
Hours: M-F 8am-5pm

Anthony J. Culotta, M.D. | **Ophthalmology** | **(All Ages)**
Retina Institute of California | **Retinology**
500 S. Anaheim Hills Rd., Suite 240 | Tel: (714) 921-0232 | **CCS: No**
Anaheim, CA 92807 | Fax: (714) 921-0535 | **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Provider's Languages: Italian
Staff's Languages: Spanish, Farsi, Korean
Hospital Privileges: San Gabriel Ambulatory Surgery Center

2nd Address: 14642 Newport Ave., Suite 210 | Tel: (714) 884-3961
Tustin, CA 92780 | Fax: (714) 884-3458
Hours: M-F 8am-5pm

3rd Address: 18582 Main St. | Tel: (714) 843-5700
Huntington Beach, CA 92648 | Fax: (714) 843-5771
Hours: M-F 8am-5pm

Rose M. Cunningham-Ahumada, D.O. | **Ophthalmology** | **(All Ages)**
Eye Associates of Orange County
2621 S. Bristol St., Suite 205 | Tel: (714) 557-5777 | **CCS: No**
Santa Ana, CA 92704 | Fax: (714) 557-7710 | **CHDP: No**
CPSP: No

Board Certified:
Hours: M-F 8am-5pm
Provider Languages: Spanish
Staff's Languages: Spanish, Chinese
Hospital Privileges: South Coast Global Medical Center, St. Joseph Hospital-Orange, Saddleback Memorial Medical Center, Magnolia Outpatient Surgery Center

2nd Address: 27871 Medical Center Rd., Suite 120 | Tel: (949) 364-6688
Mission Viejo, CA 92691 | Fax: (949) 364-6689
Hours: M-F 8am-5pm
Staff Languages: Spanish

Viet V. Dang, M.D. | **Ophthalmology** | **(All Ages)**
10301 Bolsa Ave., Suite 104 | Tel: (714) 775-0898
Westminster, CA 92683 | Fax: (714) 775-4208
CCS: Yes
Board Certified: Y | **CHDP: No**
Hours: M, W, Th, F 10am-6pm; T 9am-5pm; Sat 9am-2pm | **CPSP: No**
Provider Languages: Vietnamese, French
Staff Languages: Vietnamese, French, Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, St. Joseph Hospital-Orange

Kourosh Dastgheib, M.D. | **Ophthalmology** | **(All Ages)**
12665 Garden Grove Blvd. Suite 301 | Tel: (949) 652-6966 | **CCS: No**
Garden Grove CA 92843 | Fax: (714) 422-0960 | **CHDP: No**
CPSP: No

Hours: M-F 9am-5:30pm
Provider Languages: French, Farsi, Spanish, German
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Garden Grove Hospital Medical Center, Talbert Surgical Associates, Magnolia Surgery Center, Memorial Care Surgery Center

Julie L. Gasperini, M.D. | **Ophthalmology** | **(All Ages)**
Carson, McBeath & Boswell, Inc. | **Retinology**
7677 Center Ave., Suite 302 | Tel: (714) 657-7809 | **CCS: No**
Huntington Beach, CA 92647 | Fax: (714) 657-7811 | **CHDP: No**
CPSP: No

Board Certified: Y (Ophthalmology only)
Hours: M-F 8:30am-5pm
Staff Languages: Spanish, Korean, Vietnamese
Hospital Privileges: Long Beach Memorial Medical Center, Torrance Memorial Medical Center, Los Alamitos Medical Center

2nd Address: 4300 Long Beach Blvd., Suite 300 | Tel: (562) 984-7024
Long Beach, CA 90807 | Fax: (562) 428-7394
Hours: M-F 8:30am-5pm

Kweku Grant-Acquah, M.D. | **Ophthalmology** | **(All Ages)**
Retina Insitute of California
1403 N. Tustin Ave, Suite 399
Santa Ana, CA 92705
Tel: (800) 898-2020
Fax: (844) 897-3788

Board Certified: N
Hours: M-F 8am-5pm
Staff's Languages: Spanish
Hospital Privileges: Little Company of Mary Hospital

Yong Seok Han, M.D. | **Ophthalmology** | **(18 years and older)**
Carson McBeath & Boswell, Inc.
4300 Long Beach Blvd., Suite 300
Long Beach, CA 90807
Tel: (562) 984-7024
Fax: (562) 984-9497
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: 8am-5pm
Providers Language: Spanish
Staff Language: Spanish, Korean, Vietnamese
Hospital Privileges: Long Beach Memorial Medical Center, Torrance Memorial Medical Center, Los Alamitos Medical Center

Omar Krad, M.D. | **Ophthalmology** | **(All Ages)**
Eye Associates of Orange County
2621 S. Bristol St., Suite 205
Santa Ana, CA 92704
Tel: (714) 557-5777
Fax: (714) 557-7710
CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 8am-5pm
Provider Languages: Arabic, Spanish
Staff Languages: Spanish, Chinese
Hospital Privileges: South Coast Global Medical Center, Mission Hospital Regional Medical Center, Children's Hospital at Mission, Mission Surgery Center, Saddleback Valley Outpatient

2nd Address: 27871 Medical Center Rd., Suite 120
Mission Viejo, CA 92691
Hours: M-F 8am-5pm
Staff Languages: Spanish
Tel: (949) 364-6688
Fax: (949) 364-6689

Arthur C. Lu, M.D. | **Ophthalmology** | **(All Ages)**
14571 Magnolia St., Suite 205
Westminster, CA 92683
Tel: (714) 894-4599
Fax: (714) 897-7367
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M, T, W, F 9am-5pm; Th 9am-1pm
Staff Languages: Chinese, Vietnamese
Hospital Privileges: Admit Provider

George L. Mayo, M.D. | **Ophthalmology (Retina Vitreous ONLY)** | **(All Ages)**
Mayo Retina, Inc.
12665 Garden Grove Blvd., Suite 300
Garden Grove, CA 92843
Tel: (714) 531-6296
Fax: (714) 531-6236
CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours:M, T 9am-5pm; W 9am-6:30pm; Th, F 9am-6pm
Provider Languages: Spanish
Staff Languages: Vietnamese
Hospital Privileges: Anaheim Regional Medical Center

Desmond McGuire, M.D. | **Ophthalmology** | **(All Ages)**
Retina Associates of Orange County | **(Retina ONLY)**
2010 E. 1st St., Suite 140 | Tel: (714) 543-6020 | **CCS: No**
Santa Ana, CA 92705 | Fax: (714) 543-1720 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5pm
Provider Languages: Spanish
Hospital Privileges: Orange County Global Medical Center, St. Joseph Hospital-Orange

2nd Address: 23521 Paseo de Valencia, Suite 207 | Tel: (949) 707-5125
Laguna Hills, CA 92653 | Fax: (949) 707-5129
Hours: M-F 8:30am-6pm
Staff Languages: Spanish

3rd Address: 360 San Miguel Dr., Suite 407 | Tel: (949) 706-3514
Newport Beach, CA 92660
Hours: Mon 1:30 pm – 5:00pm; Tues, Thurs 8:30am-12:00pm

Randall L. Nguyen, M.D. | **Ophthalmology** | **(All Ages)**
Carson, McBeath & Boswell, Inc. | **Retinology**
7677 Center Ave., Suite 302 | Tel: (714) 657-7809 | **CCS: Yes**
Huntington Beach, CA 92647 | Fax: (714) 657-7811 | **CHDP: No**
CPSP: No

Board Certified: Y (Ophthalmology only)
Hours: M-F 8:30am-5pm
Provider Languages: Vietnamese, Spanish
Staff Languages: Spanish, Korean, Vietnamese
Hospital Privileges: Long Beach Memorial Medical Center, Los Alamitos Medical Center, Torrance Memorial Medical Center

2nd Address: 4300 Long Beach Blvd., Suite 300 | Tel: (562) 984-7024
Long Beach, CA 90807 | Fax: (562) 428-7394
Hours: M-F 8:30am-5pm
Staff Languages: Spanish, Korean, Vietnamese

Richard L. Nguyen, M.D. | **Ophthalmology** | **(All Ages)**
9746 Westminster Ave., Suite D4 | Tel: (714) 638-4433
Garden Grove CA 92844 | Fax: (714) 638-4499
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M, T, Th, F 10am-5pm; Sat 10am-2pm | **CPSP: No**
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Garden Grove Hospital & Medical Center

Triet M. Nguyen, M.D. | **Ophthalmology** | **(All Ages)**
Omnivision Medical Corporation
9286 Bolsa Ave. | Tel: (714) 899-0054 | **CCS: Yes**
Westminster CA 92683 | Fax: (714) 899-0117 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M, T, Th, F 9am-6pm; W, Sat 9am-1pm (alternating)
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Anaheim Global Medical Center

2nd Address: 14501 Magnolia St., Suite 103 | Tel: (714) 899-0054
Westminster, CA 92683 | Fax: (714) 899-0117

Nelson N. Noguchi, M.D. | **Ophthalmology** | **(All Ages)**
1211 W. La Palma Ave., Suite 609 | Tel: (714) 635-9347
Anaheim, CA 92801 | Fax: (714) 635-2970
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 8:30am-5:30pm | **CPSP: No**
Provider Languages: Japanese, Spanish
Staff Languages: Tagalog, Spanish, Cantonese
Hospital Privileges: West Anaheim Medical Center, Anaheim Regional Medical Center, St. Joseph Hospital-Orange

Harshad Patel, M.D. | **Ophthalmology** | **(5 years and older)**
Veronique Jotterand, M.D., A Medical Corporation
2865 Atlantic Ave., Suite 109 | Tel: (562) 988-2020 | **CCS: Yes**
Long Beach, CA 90806 | Fax: (562) 426-7394 | **CPSP: No**
CHDP: No

Board Certified: No
Hours: M-F 8am-5pm
Staff Languages: Spanish
Hospital Privileges: St. Mary Medical Center, Long Beach Memorial Medical Center

Morgan Renner, M.D. | **Ophthalmology/Glaucoma** | **(All Ages)**
Retina Institute of California
14642 Newport Ave., Suite 210 | Tel: (714) 884-3961 | **CCS: No**
Tustin, CA 92780 | Fax: (714) 884-3458 | **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Provider's Languages:
Staff's Languages: Spanish
Hospital Privileges: San Gabriel Ambulatory Surgery Center

2nd Address: 1640 Newport Ave., Suite 220 | Tel: (949) 873-5046
Costa Mesa, CA 92627 | Fax: (949) 873-5394
Hours: M-F 8am-5pm

3rd Address: 2240 N. Harbor Blvd., Suite 210 | Tel: (714) 278-1834
Fullerton, CA 92835 | Fax: (714) 278-1839
Hours: M-F 8am-5pm

Michael L. Roh, M.D. | **Ophthalmology** | **(All Ages)**
Carson, McBeath & Boswell, Inc. | **Retinology**
7677 Center Ave., Suite 302 | Tel: (714) 657-7809 | **CCS: Yes**
Huntington Beach, CA 92647 | Fax: (714) 657-7811 | **CHDP: No**
CPSP: No

Board Certified: Y (Ophthalmology only)
Hours: M-F 8:30am-5pm
Provider Languages: Korean
Staff Languages: Spanish, Korean, Vietnamese
Hospital Privileges: Long Beach Memorial Medical Center, Torrance Memorial Medical Center, Los Alamitos Medical Center

2nd Address: 4300 Long Beach Blvd., Suite 300 | Tel: (562) 984-7024
Long Beach, CA 90807 | Fax: (562) 428-7394
Hours: M-F 8:30am-5pm
Staff Languages: Spanish, Korean, Vietnamese

Michael Abed Sheety, M.D. | **Ophthalmology**
OC Surgical Eye Institute
2010 E. 1st Street, Ste. 160 | Tel: (714) 647-1200 | **CCS: YES**
Santa Ana, CA 92705 | Fax: (714) 367-6724

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Los Alamitos Medical Center, Children's Hospital of Orange County, St. Joseph Hospital, Orange County Global

Kevin Suk, M.D. | **Ophthalmology** | **(All Ages)**
Retina Institute of California | **Retinology**
11525 Brookshire Ave, Ste 201A | Tel: (800) 898-2020 | **CCS: No**
Downey, CA 90241 | Fax: (844) 897-3788 | **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Provider's Languages: Korean
Staff's Languages:
Hospital Privileges: Anaheim Regional Medical Center, Presbyterian Inter-Community Hospital, San Gabriel Ambulatory Surgery Center

2nd Address: 12828 Harbor Blvd., Ste 305 | Tel: (800) 898-2020
Garden Grove, CA 92840 | Fax: (844) 897-3788
Hours: M-F 8am-5pm

3rd Address: 18582 Main St | Tel: (800) 898-2020
Huntington Beach, CA 92648 | Fax: (844) 897-3788
Hours: M-F 8am-5pm

4th Address: 5451 La Palma Ave, Ste 44 | Tel: (800) 898-2020
La Palma, CA 90623 | Fax: (844) 897-3788
Hours: M-F 8am-5pm

Cindy Ung, M.D. | **Ophthalmology** | **(18 years and older)**
Carson Macbeth and Boswell
4300 Long Beach Blvd., Suite 300 | Tel: (562) 984-7024
Long Beach, CA 90807 | Fax: (562) 984-9477
CCS: YES
Board Certified: Y | **CHDP: NO**
Hours: M-F 8am-5pm | **CPSP: NO**
Provider Languages: Spanish, Teochew
Staff's Languages: Spanish, Korean, Vietnamese
Hospital Privileges: Long Beach Memorial Center, Los Alamitos Medical Center, MemorialCare Surgical Center - LB

Hoai T. Tran, O.D. | **Optometry** | **(All Ages)**
In Focus Optometry
15972 Euclid St., Suite G | Tel: (714) 531-7626 | **CCS: No**
FountainValley CA 92708 | Fax: (714) 531-7608 | **CHDP: No**
CPSP: No

Hours: M, T, F 10am-6pm; Th, Sa 10am-5pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese

Kevin S. Tran, O.D. | **Optometry** | **(All Ages)**
C & K Vision
9131 Bolsa Ave, Suite 202 | Tel: (714) 896-0788 | **CCS: No**
Westminster CA 92683 | Fax: (714) 898-0359 | **CHDP: No**
CPSP: No

Hours: Tu, W, Th, F 10am-6pm; Sat 10am-4pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese

Duke Ahn, M.D. | **Orthopedic Surgery** | **(All Ages)**
ProHealth Partners a Medical Group
3700 Katella Ave, Suite C | Tel: (562) 583-2250
Los Alamitos, CA 90702 | Fax: (562) 583-2254

Board Certified: Yes
Hours: M-F 9am-5:30pm
Staff Languages: Spanish
Hospital Privileges: Los Alamitos Medical Center, La Palma Inter-Community Hospital

Afshin Aminian, M.D. | **Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr., Suite 508 | Tel: (714) 633-2111 | **CCS: Yes**
Orange, CA 92868 | Fax: (714) 633-5615 | **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Board Certified: Y
Staff Languages: Spanish, French
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Children's Hospital of Orange County

2nd Address: 25982 Pala Dr., Suite 230 | Tel: (949) 600-8800
Mission Viejo, CA 92691 | Fax: (949) 600-8813
Hours: M-F 8am-5pm
Staff Languages: Spanish

Lisa Ann Cao, M.D. | **Pediatric Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr, Ste 508 | Tel: (714-633-2111
Orange, CA 92868 | Fax: (844) 387-7625

Board Certified: No
Hours: M-F 8am-5pm
Provider's Languages: Spanish
Hospital Privileges: CHOC Choldren's Hospital

Jeffrey L. Dobyns, M.D. | **Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr., Suite 508 | Tel: (714) 633-2111 | **CCS: Yes**
Orange, CA 92868 | Fax: (714) 633-5615 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Staff Languages: Spanish, French
Hospital Privileges: Children's Hospital of Orange County, St. Joseph Hospital-Orange

Edward Green III, M.D. | **Orthopedic Surgery** | **(5 years and older)**
ProHealth Partners
1040 Elm Ave., Suite 100 | Tel: (562) 591-4444 | **CCS: No**
Long Beach, CA 90813 | Fax: (562) 431-8882 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5:30pm
Provider's Languages:
Staff's Languages: Spanish
Hospital Privileges: Long Beach Memorial Medical Center, St. Mary Medical Center, Los Alamitos Medical Center

2nd Address: 3801 Katella Ave., Suite 212 Tel: (562) 430-3561
Los Alamitos, CA 90720 Fax: (562) 431-8882

Kunal Kalra, M.D. | **Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr., Suite 508 | Tel: (714) 633-2111 | **CCS: No**
Orange, CA 92868 | Fax: (844) 387-7625 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Hospital Privileges: CHOC Children's Hospital

Francois D. Lalonde, M.D. | **Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr., Suite 508 | Tel: (714) 633-2111 | **CCS: Yes**
Orange, CA 92868 | Fax: (714) 633-5615 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: French
Staff Languages: Spanish, French
Hospital Privileges: Children's Hospital of Orange County, Children's Hospital at Mission

2nd Address: 25982 Pala Dr., Suite 230 | Tel: (949) 600-8800
Mission Viejo, CA 92691 | Fax: (949) 600-8813
Hours: M-F 8am-5pm

Amirhossein Misaghi, M.D. | **Orthopedic Surgery** | **(0-21 years old)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr., Suite 508 | Tel: (714) 633-2111 | **CCS: Yes**
Orange, CA 92868 | Fax: (844) 387-7625 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M-F 8am-5pm
Provider Languages:
Staff Languages: Spanish
Hospital Privileges: Children's Hospital of Orange County

2nd Address: 25982 Pala Dr., Suite 230 | Tel: (714) 633-2111
Mission Viejo, CA 92691 | Fax: (844) 387-7625
Hours: M-F 8am-5pm

3rd Address: 4980 Barranca Parkway, Suite 220
Irvine, CA 92604
Hours: M-F 8am-5pm

Aditi Majumdar, M.D. | **Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialists
1310 W. Stewart Drive., Suite 508 | Tel: (714) 633-2111
Orange, CA 92868 | Fax: (844) 387-7625

Board Certified: N
Hours: M-F 8am-5pm
Hospital Privileges: CHOC Children's Hospital, St. Joseph Hospital

2nd Address: 25982 Pala, Suite 230 | Tel: (714) 633-2111
Mission Viejo, CA 92691 | Fax: (844) 387-7625

3rd Address: 4980 Barranca Pkwy., #220 | Tel: (714) 633-2111
Irvine, CA 92604 | Fax: (844) 387-7625

Trong B. Nguyen, M.D. | **Orthopedic Surgery/Sports Medicine** | **(All Ages)**
The Center for Bone & Joint Care
18035 Brookhurst St., Suite 1100 | Tel: (714) 861-4888 | **CCS: Yes**
Fountain Valley, CA 92708 | Fax: (714) 861-4777 | **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Provider's Languages: Vietnamese
Staff's Languages: Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Long Beach Memorial Medical Center, Orange Coast Memorial Medical Center, Orange County Global Medical Center

OrthoWest
947 S. Anaheim Blvd., Suite 125 | Tel: (714) 241-7000
Anaheim, CA 92805 | Fax: (714) 241-7003
Hours: M-F 8am-5pm

Richard H. Blanks, M.D. | **(All Ages)**
Staff's Languages: Spanish, Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Anaheim Regional Medical Center, Placentia Linda Hospital, Foothill Regional Medical Center

Jason A. Grieshober, M.D.
Staff's Languages: Spanish, Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Anaheim Regional Medical Center, Foothill Regional Hospital

Samuel R. Rosenfeld, M.D. | **Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr., Suite 508 | Tel: (714) 633-2111 | **CCS: Yes**
Orange, CA 92868 | Fax: (714) 633-5615 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Staff Languages: Spanish
Hospital Privileges: St. Joseph Hospital-Orange, Long Beach Memorial Medical Center, Children's Hospital of Orange County

2nd Address: 25982 Pala Dr., Suite 230 | Tel: (949) 600-8800
Mission Viejo, CA 92691 | Fax: (949) 600-8813
Hours: M-F 8am-5pm
Staff Languages: Spanish

Carl R. Weinert, M.D | **Orthopedic Surgery** | **(All Ages)**
Adult & Pediatric Orthopedic Specialist, Inc.
1310 W. Stewart Dr., Suite 508 | Tel: (714) 633-2111 | **CCS: Yes**
Orange, CA 92868 | Fax: (714) 633-5615 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M-F 8am-5pm
Staff Languages: Spanish, French
Hospital Privileges: St. Joseph Hospital-Orange, UCI Medical Center, Children's Hospital of Orange County

2nd Address: 25982 Pala Dr., Suite 230 | Tel: (949) 600-8800
Mission Viejo, CA 92691 | Fax: (949) 600-8813
Hours: M-F 8am-5pm
Staff Languages: Spanish

Ahmad Hajj, M.D. | **Orthopedic Surgery** | **(2 years and older)**
Ahmad Hajj, M.D., Inc.
1220 Hemlock Way, Suite 203 | Tel: (714) 957-5721 | **CSS: Yes**
Santa Ana, CA 92707 | Fax: (714) 957-5872 | **CHDP: No**
CPSP: No

Hours: M-F 8am-5pm
Provider Languages: Arabic
Staff Languages: Spanish
Hospital Privileges: Chapman Global Medical Center, South Coast Global Medical Center

Tam M. Bui, M.D. | **Otolaryngology** | **(All Ages)**
11180 Warner Ave., Suite 459
Fountain Valley, CA 92708
Tel: (714) 545-1133
Fax; (714) 545-1144

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-Th 9am-6pm; F 9am-5pm
Provider Languages: German, Vietnamese, French
Staff Languages: Vietnamese, German, French
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Quang C. Quach, D.O. | **Otolaryngology** | **(2 years and older)**
9251 Bolsa Ave.
Westminster, CA 92683
Tel: (714) 248-9841
Fax: (714) 248-9843

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9:30am-5pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital, Garden Grove Hospital & Medical Center

Amy M. Nguyen, M.D. | **Otolaryngology** | **(All Ages)**
OC Voice-Ear, Nose and Throat Center, Inc.
13031 Kerry Street
Garden Grove, CA 92844
Tel: (714) 930-6989
Fax: (888) 764-9650

CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M,T,Th, F 9am-6pm; Sat 10am-2pm
Provider Languages: Vietnamese, Spanish
Staff Languages: Vietnamese

Chiwai E. Chan, D.O. | **Pain Management** | **(All Ages)**
Orange County Pain Center
11160 Warner Ave., Suite 417
Fountain Valley, CA 92708
Tel: (714) 424-9300
Fax: (714) 424-9324

CCS: No
CHDP: No
CPSP: No

Hours: M-F 9am-5pm
Provider Languages: Chinese
Staff Languages: Chinese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

2nd Address: 24953 Paseo De Valencia, Suite 7A
Laguna Hills, CA 92653
Tel: (949) 215-6611
Fax: (714) 424-9324
Hours: M-F 9am-5pm
Staff Languages: Chinese, Vietnamese, Spanish, Farsi

Phillip H. Lim, D.O. | **Pain Management** | **(All Ages)**
NuVation Pain Group
5832 Beach Blvd., Suite 210
Buena Park, CA 90621
Tel: (714) 676-5541
Fax: (714) 676-5542

CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-4pm
Languages: Korean, Spanish
Hospital Privileges: West Anaheim Medical Center, Anaheim Regional Medical Center, Hollywood Presbyterian Medical Center, Good Samaritan Hospital, Los Robles Medical Center, St. Jude Medical Center

Phuong Q. Tien, M.D. | **Pain Medicine/Physical Medicine & Rehab** | **(18 years and older)**
Newhope Joint & Spine Medical Center, Inc.
14120 Beach Blvd. Ste 180
Westminster, CA 92683
Tel: (714) 333-3333
Fax: (714) 891-3234

CCS: No
CHDP: No
CPSP: No

Board Certified:
Hours: Tues – Saturday 9am – 6pm
Provider Languages: Vietnamese, Cantones
Staff's Languages: Vietnamese, Spanish
Hospital Privileges: Admit Panel

James M. Chu, M.D. | **Pediatric Cardiology** | **(0-18 years)**
Pediatrix Cardiology of Orange County, P.C.
1010 W. La Veta Ave., Suite 575
Orange, CA 92868
Tel: (714) 547-0900
Fax: (714) 547-2080
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Chinese, Mandarin, Spanish
Staff Languages: Spanish
Hospital Privileges: Children's Hospital of Orange County, Hoag Memorial Hospital Presbyterian, Los Alamitos Medical Center, Long Beach Memorial Medical Center, St. Joseph Hospital-Orange, Saddleback Memorial Medical Center

CHOC Children's Specialists | **Pediatric Cardiology** | **FACILITY-BASED**
1201 W. La Veta Ave.
Orange, CA 92868
Tel: (714) 509-3939
Fax: (714) 509-3949

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

Anthony C. Chang, M.D. **CCS: Yes**

Nita Doshi, M.D. **CCS: Yes**

Maria S. Horenstein, M.D.

Giro S. Morchi, M.D. **CCS: Yes**

Pierangelo Renella, M.D. **CCS: Yes**

Ahmad Ellini, M.D. | **Pediatrics Cardiology** | **(0-18 years)**
1010 W. La Veta Ave. Suite 575
Orange, CA 92868
Tel: (714) 547-0900
Fax: (714) 547-2080
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M – F 8am – 5:30pm
Providers Languages: Farsi
Staff's Languages:
Hospital Privileges: Saddleback Momerial Medical Center, Childrens Hospital of Orange County, Arrowhead Regional Medical Center, Western Medical Center, Long Beach Medical Center, Tri City Medical Center, St. Joseph Hospital,Beverly Hospital, Mission Hospital, Fountain Valley Regional Hospital, Torrance Memorial Medical Center, Hoag Memorial Hospital Presbyterian, Los Alamitos Medical Center

Keith M. Weiner, M.D. | **Pediatric Cardiology** | **(0-21 years)**
Orange County Pediatric Cardiology Group
1310 W. Stewart Drive, Suite 601
Orange CA 92868
Tel: (714) 538-8887
Fax: (714) 538-6672
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-Th 8am-5pm; F 8am-4:30pm
Provider Languages: Spanish
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Children's Hospital of Orange County, Hoag Memorial Hospital Presbyterian

2nd Address: 26691 Plaza, Suite 210
Mission Viejo, CA 92691
Tel: (949) 218-0845
Fax: (949) 218-0847

CHOC Children's Specialists | **Pediatric Critical Care** | **FACILITY-BASED**
Francis Y. Kim, M.D.
1201 W. La Veta Ave.
Orange, CA 92868
Tel: (714) 509-7601
Fax: (714) 509-4072

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

Praful A. Sarode, M.D. — **Pediatric Critical Care** — **(0-21 years)**
17456 Beach Blvd., Suite 101
Huntington Beach, CA 92647
Tel: (714) 847-8551
Fax: (714) 316-1261

Board Certified: Y
Hours: M-Sat 8am-5pm
CCS: Yes
Provider Languages: Hindi
Staff Languages: Hindi, Spanish, Urdu
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Children's Hospital of Orange County, Orange County Global Medical Center

2nd Address: 999 N. Tustin Ave., Suite 124
Santa Ana, CA 92705
Hours: M-F 9am-5pm
Staff Languages: Spanish, Hindi, Urdu
Tel: (714) 547-5444
Fax: (714) 316-1261

Griselda Alvarez, M.D. — **Pediatric Endocrinology** — **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave.
Long Beach, CA 90806
Tel: (562) 933-8279
Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220
Long Beach, CA 90806
Tel: (562) 933-8562
Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200
Long Beach, CA 90806
Tel: (562) 728-5005
Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102
Torrance, CA 90505
Tel: (562) 933-6730
Fax: (562) 933-6743

Roja Fallah, M.D. — **Pediatric Endocrinology** — **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave.
Long Beach, CA 90806
Tel: (562) 933-8279
Fax: (562) 933-3089

Board Certified: No
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220
Long Beach, CA 90806
Tel: (562) 933-8562
Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200
Long Beach, CA 90806
Tel: (562) 728-5005
Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102
Torrance, CA 90505
Tel: (562) 933-6730
Fax: (562) 933-6743

Rebecca Hicks, M.D. — **Pediatric Endocrinology** — **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave.
Long Beach, CA 90806
Tel: (562) 933-8279
Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220
Long Beach, CA 90806
Tel: (562) 933-8562
Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200
Long Beach, CA 90806
Tel: (562) 728-5005
Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102
Torrance, CA 90505
Tel: (562) 933-6730
Fax: (562) 933-6743

Erin Okawa, M.D. | **Pediatric Endocrinology** | **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

CHOC Children's Specialists | **Pediatric Endocrinology** | **FACILITY-BASED**
455 S. Main St. Tel: (714) 509-8634
Orange, CA 92868 Fax: (714) 509-4049

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

Amrit P.S. Bhangoo, M.D. | **CCS: Yes**

Lien N. Trinh, M.D. | **CCS: Yes**

CHOC Children's Specialists | **Pediatric Gastroenterology** | **FACILITY-BASED**
1201 W. La Veta Ave. Tel: (714) 509-4099
Orange, CA 92868 Fax: (714) 509-3301

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

Ashish Chogle, M.D. | **CCS: No**

Kenneth E. Grant, M.D. | **CCS: Yes**

Jacqueline Casillas, M.D. | **Pediatric Hematology/Oncology** | **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Satiro De Oliveira, M.D. **Pediatric Hematology/Oncology** **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Pamela Kempert, M.D. **Pediatric Hematology/Oncology** **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Aditi Mehta, M.D. **Pediatric Hematology/Oncology** **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: No
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Theodore Moore, M.D. **Pediatric Hematology/Oncology** **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Ramesh Patel, M.D. **Pediatric Hematology/Oncology** **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Gavin Roach, M.D. **Pediatric Hematology/Oncology** **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: No
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Maritza Ruiz, M.D. **Pediatric Hematology/Oncology** **All Ages**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-6743

Laurel Truscott, M.D. **Pediatric Hematology/Oncology** **(All Ages)**
UCLA Medical Group
Miller Children's & Women's Hospital
2801 Atlantic Ave. Tel: (562) 933-8279
Long Beach, CA 90806 Fax: (562) 933-3089

Board Certified: Yes
Hospital Privileges: Miller Children's & Women's Hospital Medical Center

2nd Address: 2880 Atlantic Ave., Suite 220 Tel: (562) 933-8562
Long Beach, CA 90806 Fax: (562) 933-8544

3rd Address: 2653 Elm Ave., Suite 200 Tel: (562) 728-5005
Long Beach, CA 90806 Fax: (562) 933-1815

4th Address: 3640 Lomita Blvd., Suite 102 Tel: (562) 933-6730
Torrance, CA 90505 Fax: (562) 933-3089

CHOC Children's Specialists **Pediatric Hematology/Oncology** **FACILITY-BASED**
455 S. Main St. Tel: (714) 509-8636
Orange, CA 92868 Fax: (714) 509-8699

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

David K. Buchbinder, M.D. **CCS: Yes**

Loan B. Hsieh, M.D. **CCS: Yes**

CHOC Children's Specialists **Pediatric Infectious Disease** **FACILITY-BASED**
Antonio C. Arrieta, M.D. **CCS: Yes**
455 S. Main St. Tel: (714) 509-8644
Orange, CA 92868-3874 Fax: (714) 509-4508

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County, St. Joseph Hospital-Orange

Naser Elbalalesy, M.D. | **Pediatric Neurology** | **(All Ages)**
17822 Beach Blvd., Suite 374 | Tel: (714) 848-3333
Huntington Beach, CA 92647 | Fax: (714) 698-1652

CCS: Yes
Board Certified: Y | **CHDP: No**
Hours: T-Th, Sat 9am-5pm | **CPSP: No**
Staff Languages: Arabic, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Children's Hospital of Orange County, Children's Hospital at Mission, St. Joseph Hospital

2nd Address: 26800 Crown Valley Pkwy., Suite 460 Tel: (714) 848-3333
Mission Viejo, CA 92691 Fax: (714) 848-3301

CHOC Children's Specialists | **Pediatric Neurology** | **FACILITY-BASED**
455 S. Main St. | Tel: (714) 509-7601
Orange, CA 92868-3874 | Fax: (714) 509-7650

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County, UCI Medical Center

Amanda N. Fernandez, M.D. **CCS: Yes**

Ira T. Lott, M.D. **CCS: Yes**

Joffre E. Olaya, M.D. **CCS: Yes**

Sanford Schneider, M.D. **CCS: Yes**

Daniel W. Shrey, M.D.

Minodora O. Totoiu, M.D. **CCS: Yes**

Mary L. Zupanc, M.D. **CCS: Yes**

CHOC Children's Specialists | **Pediatric Oncology** | **FACILITY-BASED**
Carol H. Lin, M.D.
1201 W. La Veta Ave. | Tel: (714) 509-7601
Orange, CA 92868 | Fax: (855) 246-2329

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

CHOC Children's Specialists | **Pediatric Ophthalmology** | **FACILITY-BASED**
455 S. Main St. | Tel: (714) 289-2389
Orange, CA 92868 | Fax: (714) 289-2390

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

2nd Address: 845 W. La Veta Ave., Suite 107B Tel: (714) 289-2389-
Orange, CA 92868 Fax: (714) 289-2390

David Sami, M.D. **CCS: Yes**

Sidney J. Weiss, M.D.

Veronique H. Jotterand, M.D. | **Pediatric Ophthalmolgy** | **(0 to 5 years old)**
2865 Atlantic Ave., Suite 109 | Tel: (562) 988-2020
Long Beach, CA 90806 | Fax: (562) 426-7394

CCS: YES
Board Certified: Y | **CHDP: YES**
Hours: M-F 8am-5pm | **CPSP: NO**
Provider's Languages: Spanish, French, German, Italian
Staff's Languages: Spanish, Korean, Italian
Hospital Privileges: **St. Mary's Medical Center**, Long Beach Memorial Medical Center, Fountain Valley Regional Hospital

CHOC Children's Specialists | **Pediatric Otolaryngology** | **FACILITY-BASED**
Gurpeet S. Ahuja, M.D. | | **CCS: Yes**
455 S. Main St. | Tel: (714) 633-4020
Orange, CA 92868 | Fax: (714) 953-5462

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

2nd Address: 1010 W. La Veta Ave., Suite 640 | Tel: (714) 633-4020
Orange, CA 92868 | Fax: (714) 953-5462

CHOC Children's Specialists | **Pediatric Pulmonary Disease** | **FACILITY-BASED**
Chana Chin, M.D.
1201 W. La Veta Ave. | Tel: (714) 509-7601
Orange, CA 92868 | Fax: (855) 246-2329

Hours: M-F 8am-4:30pm
Hospital Privileges: Children's Hospital of Orange County

Kelly Davis, M.D. | **Pediatric Sports Medicine** | **(0-16 years old)**
Adult and Pediatric Orthopedic Specialists
1310 W. Stewart Dr., Ste. 508 | Tel: (714) 633-2111 | **CCS: Yes**
Orange, Ca 92868 | Fax: (714) 844) 3877625 | **CHDP: No**
CPSP: No

Hours: M-F 8am – 5pm
Hospital Privileges: CHOC Children's Hospital; Loma Linda University Hospital

2nd Address: 259952 Pala Ste. 230 | Tel: (714) 633-2111
Mission Viejo, Ca 92691 | Fax: (844) 387-7625

Jeffrey T. Ho, D.O. | **Physical Medicine & Rehab** | **(17 years and older)**
9191 Westminster Ave., Suite 209 | Tel: (714) 894-6600
Garden Grove, CA 92683 | Fax: (714) 583-6367

CCS: No
Board Certified: Y | **CHDP: No**
Hours: Tu, F 1pm-5pm | **CPSP: No**
Languages: Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Long Beach Memorial Medical Center, Lakewood Regional Medical Center

D. Michelle Thai, M.D. | **Physical Medicine & Rehab** | **(3 years and older)**
16401 Magnolia St. | Tel: (714) 596-4288
Westminster, CA 92683 | Fax: (714) 596-2388

CCS: Yes
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-6pm | **CPSP: No**
Provider Languages: Vietnamese
Staff Languages: Vietnamese, Spanish, Japanese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center

Rey Louie Armenion, P.T. | **Physical Therapy** | **5 years and older**
Active Sports Rehab Physical Therapy, Inc.
6850 Lincoln Ave., Suite 205 | Tel: (714) 527-9240 | **CCS: No**
Buena Park, CA 90620 | Fax: (714) 527-9230 | **CHDP: No**
CPSP: No

Provider Languages: Tagalog
Staff Languages: Tagalog, Spanish

State College Physical Therapy, Inc. | **Physical Therapy** | **(7 years and older)**
Parivash F. Oreizy, P.T.
215 N. State College Blvd., Suite G
Anaheim, CA 92806

Tel: (714) 999-6596
Fax: (714) 999-5009

CCS: No
CHDP: No
CPSP: No

Hours: M-F 8am-7pm
Provider Languages: Farsi
Staff Languages: Spanish, Vietnamese, Farsi

2nd Address: 500 S. Anaheim Hills Rd., Suite 106
Anaheim Hills, CA 92807
Hours: M-F 8am-7pm
Staff Languages: Spanish, Farsi

Tel: (714) 999-6596
Fax: (714) 999-5009

Urvashi Barbhaya, P.T. | **Physical Therapy** | **(All Ages)**
All Care Therapies
4300 Long Beach Blvd, Ste 700
Long Beach, CA 90807

Tel: (818) 894-2273
Fax: (818) 357-2505

IN PROCESS

Board Certified: No
Hours: M-F: 8am-6pm
Provider's Languages: Spanish, Indian, Armenian, Farsi, Arabic
Staff's Languages: Spanish, Indian, Armenian, Farsi, Arabic

Marilou Bollier, P.T. | **Physical Therapy** | **(All Ages)**
Active Sports Rehab and Wellness Program
13330 Bloomfield Ave., Suite 101
Norwalk, CA 90650

Tel: (562) 484-3860
Fax: (562) 684-4070

Hours: M-F 9am-6pm
Provider Languages: Tagalog, Spanish
Staff Languages: Spanish, Tagalog

Sonia Chopra Dhir, P.T. | **Physical Therapy** | **(All Ages)**
All Care Therapies
4300 Long Beach Blvd, Ste 700
Long Beach, CA 90807

Tel: (818) 894-2273
Fax: (818) 357-2505

IN PROCESS

Board Certified: No
Hours: M-F: 8am-6pm
Provider's Languages: Spanish, Indian, Armenian, Farsi, Arabic
Staff's Languages: Spanish, Indian, Armenian, Farsi, Arabic

Evelyn Co, P.T. | **Physical Therapy** | **(All Ages)**
Active Sports Rehab and Wellness Program
13330 Bloomfield Ave., Suite 101
Norwalk, CA 90650

Tel: (562) 484-3860
Fax: (562) 484-3861

Hours: M-F 9am-6pm
Provider Languages: Tagalog, Spanish
Staff Languages: Spanish, Tagalog

Maria Alexa Crosby, P.T. | **Physical Therapy** | **(All Ages)**
Active Sports Rehab and Wellness Program
13330 Bloomfield Ave., Suite 101
Norwalk, CA 90650

Tel: (562) 484-3860
Fax: (562) 484-3861

Hours: M-F 9am-6pm
Provider Languages: Tagalog, Spanish
Staff Languages: Spanish, Tagalog

Azar Noorafrouz, P.T. | **Physical Therapy** | **(All Ages)**
All Care Therapies | | IN PROCESS
4300 Long Beach Blvd, Ste 700 | Tel: (818) 894-2273
Long Beach, CA 90807 | Fax: (818) 357-2505

Board Certified: No
Hours: M-F: 8am-6pm
Provider's Languages: Spanish, Indian, Armenian, Farsi, Arabic
Staff's Languages: Spanish, Indian, Armenian, Farsi, Arabic

Karlu Remulta Tan, P.T. | **Physical Therapy** | **(All Ages)**
All Care Therapies | | IN PROCESS
4300 Long Beach Blvd, Ste 700 | Tel: (818) 894-2273
Long Beach, CA 90807 | Fax: (818) 357-2505

Board Certified: No
Hours: M-F: 8am-6pm
Provider's Languages: Spanish, Indian, Armenian, Farsi, Arabic
Staff's Languages: Spanish, Indian, Armenian, Farsi, Arabic

Richard Yee, P.T. | **Physical Therapy** | **(All Ages)**
All Care Therapies | | IN PROCESS
4300 Long Beach Blvd, Ste 700 | Tel: (818) 894-2273
Long Beach, CA 90807 | Fax: (818) 357-2505

Board Certified: No
Hours: M-F: 8am-6pm
Provider's Languages: Spanish, Indian, Armenian, Farsi, Arabic
Staff's Languages: Spanish, Indian, Armenian, Farsi, Arabic

Farbod Esmailian, M.D. | **Plastic Surgery** | **(0-75 years)**
10861 Cherry St., Suite 108 | Tel: (562) 430-7373
Los Alamitos, CA 90720 | Fax: (562) 430-7376

CCS: Yes
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-5pm | **CPSP: No**
Provider Languages: Farsi
Staff Languages: Spanish
Hospital Privileges: Los Alamitos Medical Center, Long Beach Memorial Medical Center, Lakewood Regional Medical Center, Miller Children's Medical Center, Orange Coast Memorial Medical Center

Wendy Ng, M.D. | **Plastic and Reconstructive Surgery** | **(All Ages)**
396 S. Main St., Suite 200
Orange, CA 92868 | Tel: (714) 988-6330
Fax: (714) 988-6360

CCS: Yes
Board Certified: Yes | **CHDP: No**
Hours: M-F 9am-5pm | **CPSP: No**
Staff Languages: Spanish
Hospital Privileges: St. Joseph's Hospital of Orange, Hoag Hospital, CHOC Children's Hospital

Tuan Anh Tran, M.D. | **Plastic Surgery/ Hand Surgery** | **(All Ages)**
10301 Bolsa Ave. Suite 101 | Tel: (714) 839-8000
Westminster, CA 92683 | Fax: (714) 839-8008

CCS: Yes
Board Certified: | **CHDP: No**
Hours: M – Th 9:00am – 6:00pm; Fri 9:00am-1:00pm | **CPSP: No**
Provider Languages: Vietnamese
Staff's Languages: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Medical Center, Orange Coast Memorial Medical Center, Saddleback Memorial Medical Center, HOAG Memorial Hospital

Steve T. Vu, M.D. | **Plastic Surgery** | **(All Ages)**
California Aesthetic Center
17742 Beach Blvd., Suite 335
Huntington Beach, CA 92647
Tel: (714) 848-1133
Fax: (714) 848-4114
CCS: No
CHDP: No
CPSP: No

Hours: M-F 9am-5:30pm
Provider's Languages: Vietnamese
Staff's Languages: Vietnamese
Hospital Privileges: Huntington Beach Hospital, Hoag Memorial Hospital Presbyterian, Golden Triangle Surgery Center

Steven J. Altman, D.P.M. | **Podiatry** | **(All Ages)**
Foothills Podiatry Group
218 W. Main St., Suite 103
Tustin, CA 92780
Tel: (714) 730-1075
Fax: (714) 730-5227
CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-F 8:30am-5:30pm
Staff Languages: Spanish
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, Chapman Global Medical Center

Chuc B. Dang, D.P.M. | **Podiatry** | **(All Ages)**
Brookhurst Foot Clinic
18821 Delaware St., Suite 101
Huntington Beach, CA 92648
Tel: (714) 775-5373
Fax: (714) 775-4236
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-6pm; Sat 9am-2pm
Languages: Vietnamese, French, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Garden Grove Hospital & Medical Center

Kevin L. Ho, D.P.M. | **Podiatry** | **(All Ages)**
14571 Magnolia Ave., Suite 206
Westminster, CA 92683
Tel: (714) 379-6400
Fax: (714) 379-6416
CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M, Th 9am-5pm; T, F, Sat 9am-12pm (open 2 Saturdays per month)
Provider Languages: Vietnamese
Staff Languages: Vietnamese
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Huntington Beach Hospital

Hyun K. Kang, D.P.M. | **Podiatry**
5451 La Palma Ave., Suite 26
La Palma, CA 90623
Tel: (714) 735-8588
Fax: (562) 249-8443
CCS: No
CHDP: No
CPSP: No

Board Certified: N
Hours: M-Th 9am-12:30pm
Provider's Languages: Korean
Staff's Languages: Korean
Hospital Privileges: La Palma Intercommunity Hospital, West Anaheim Medical Center

Sang Y. Kim, D.P.M. | **Podiatry** | **(All Ages)**
5451 La Palma Ave., Suite 26 | Tel: (714) 735-8588 | **CCS: No**
La Palma, CA 90623 | Fax: (562) 249-8443 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-Th 9am-12:30pm; F 9am-5pm
Provider's Languages: Korean
Staff's Languages: Korean
Hospital Privileges: La Palma Intercommunity Hospital, West Anaheim Medical Center, Anaheim Global Medical Center

2nd Location
520 s. Virgil Ave., Suite 105 | Tel: (213) 352-1090
Los Angeles, CA 90020 | Fax (562) 249-8443
Hours: M-Th 9am-5pm

3rd Location
3400 Lomita Blvd. Suite 305 | Tel: (424) 305-4417
Torrance, CA 90505
Hours: M-F 9am-5pm

Amir Lebaschi, D.P.M. | **Podiatry (All Ages)**
2220 E. Fruit St., Suite 214 | Tel: (714) 547-7100 | **CCS: No**
Santa Ana, CA 92701 | Fax: (714) 547-7300 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M –F 9am – 5pm
Provider's Languages: German, Farsi
Staff's Languages: Spanish
Hospitals Privileges: Anaheim Global Medical Center, Fountain Valley Regional hospital, Orange County Global Medical Center

Kelvin Nguyen, D.P.M. | **Podiatry**
13310 Euclid St. | Tel: (714) 638-2653 | **CCS: No**
Garden Grove, CA 92843 | Fax: (714) 276-1670 | **CHDP: No**
CPSP: No

Board Certified:
Hours: Tues & Fri 9am-5pm, Thurs & Sat 9am -1pm
Providers Languages: Vietnamese
Staff Languages: Spanish
Hospital Privileges: Garfield Medical Center, Doctors Surgery Center, Concourse Diagnostis Surgery Center

2nd Address
210 N. Garfield Ave. Suite 305 | Tel: (626) 310-4507
Monterey Park, CA 91754 | Fax: (626) 532-8733
Hours: Mon & Wed 9am – 5pm, Thurs 2pm – 5pm

Daniel Recalde, D.P.M. | **Podiatry** | **(All Ages)**
11100 Warner Ave., Suite 306 | Tel: (714) 979-0313 | **CCS: No**
Fountain Valley, CA 92708 | Fax: (714) 979-0340 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: Mon- Fri 9am – 4pm by Appointment
Provider Languages: Spanish, Italian, French
Staff's Languages: Hawaiian
Hospital Privileges: Fountain Valley Regional Hospital, Orange Coast Memorial, Hoag Memorial Hospital, Orange Coast Specialty Surgery Center

Robert Gheorghe Bota, M.D. | **Psychiatry** | **(18 years and older)**
Brainhealth Solutions, Inc.
136 Broadway | Tel: (949) 288-5377
Costa Mesa, CA 92627 Fax: (949) 288-5379

Board Certified: Yes
Hours: M-F 9am-6pm
Provider Languages: Romanian
Staff Languages: Spanish
Hospital Privileges: Admit Panel

Lawrence O. Ogbechie, M.D. | **Psychiatry** | **(All Ages)**
Serenity Care Health Group
2100 E. Anaheim St., Suite B
Long Beach, CA 9804
Tel: (562) 478-4102
Fax: (562) 478-4105

Board Certified: No
Hours: M-F 8am-5pm; Sat 8am-12pm
Staff Languages: Spanish, Tagalog, Khmer
Hospital Privileges: College Medical Center

Karina Shulman, M.D. | **Psychiatry** | **(All Ages)**
Accumen Healthcare
7840 Imperial Hwy, Suite B
Downey, CA 90242
Tel: (213) 784-7918
Fax: (213) 784-7905

Board Certified: No
Hours: M-F 8am-5pm
Provider Languages: Russian
Staff Languages: Spanish, Russian
Hospital Privileges: Admit Panel

Robby T. Ayoub, M.D. | **Pulmonary Disease / Critical Care Hospitalist** | **(18 years and older)**
8201 Newman Ave., Suite 302
Huntington Beach, CA 92674
Tel: (714) 847-6900
Fax: (714) 847-3900
CCS: No
CHDP: No
CPSP: No

Board Certified: Y (Pulmonary Disease & Critical Care Medicine)
Hours: M-F: 8:30am-5pm; Sat: 8:30am-2pm
Provider Languages: Arabic, French, Spanish
Staff Languages: Spanish, Tagalog
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center

Khaled Chan, M.D. | **Pulmonary Disease** | **16 years and older**
Pathway Medical Group, Inc.
7955 Westminster Blvd
Westminster, CA 92683
Tel: (714) 379-3221
Fax: (714) 379-3211
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Arabic
Staff Languages: Spanish
Hospital Privileges:

Asaad Hakim, M.D. | **Pulmonary Disease** | **(All Ages)**
Pathway Medical Group, Inc.
12555 Garden Grove Blvd., Suite 502A
Garden Grove, CA 92843
Tel: (714) 537-7800
Fax: (714) 537-7633
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5pm
Languages: Arabic
Hospital Privileges: Garden Grove Hospital & Medical Center, Fountain Valley Regional Hospital & Medical Center, South Coast Global Medical Center, Anaheim Global Medical Center

Anooshiravan Hami, M.D. | **Pulmonary Disease**
Critical Care Medicine | **(All Ages)**
3400 W. Ball Road
Anaheim, CA 92804
Tel: (714) 826-7440
Fax: (714) 826-4623
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8:30am-5pm
Hospital Privileges: West Anaheim Medical Center, La Palma Intercommunity Hospital, St. Joseph Hospital-Orange, Newport Specialty Hospital (Foothill Regional Medical Center), Kindred Hospital-Brea, Kindred Hospital-Westminster, Tustin Rehabilitation (HealthSouth)

Alexander J. Sweidan, M.D. | **Pulmonary Disease** | **(16 years and older)**
Mesa Pulmonary Group, Inc. | **Critical Care Medicine**
136 Broadway | Tel: (949) 548-5111 | **CCS: Yes**
Costa Mesa, CA 92627 | Fax: (949) 548-2575 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-Thurs 9:00am – 5:00pm
Provider Languages: Romanian, Polish, Spanish
Staff Languages: Spanish, Vietnamese
Hospital Privileges: Hoag Memorial Hospital Presbyterian, Fountain Valley Regional Hospital

Navneet Singh, D.O. | **Pulmonary Disease** | **(16 years and older)**
Mesa Pulmonary Group, Inc. | **Critical Care Medicine**
136 Broadway | Tel: (949) 548-5111 | **CCS: Yes**
Costa Mesa, CA 92627 | Fax: (949) 548-2575 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-Thurs 9:00am – 5:00pm
Provider Languages: Hindi, Punjabi
Staff's Languages: Spanish, Vietnamese
Hospital Privileges: Hoag Memorial Hospital Presbyterian, Kindred Hospital-Westminster

Chu-Pei Feng, M.D. | **Radiation Oncology** | **(All Ages)**
Orange County Radiation Oncology Medical Group.
1100 N. Tustin Ave., Suite A | Tel: (714) 835-8520 | **CCS: Yes**
Santa Ana, CA 92705 | Fax: (714) 835-3610 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Chinese
Staff Languages: Spanish, Chinese, Vietnamese, Korean, Mandarin
Hospital Privileges: Orange County Global Medical Center, Anaheim Regional Medical Center

Vijaykumar R. Kini, M.D. | **Radiation Therapy** | **(18 years and older)**
Radiation Oncology Medical Group of Southern California
2895 Edinger Ave. | Tel: (949) 381-5800 | **CCS: No**
Tustin, CA 92780 | Fax: (949) 552-5152 | **CHDP: No**
CPSP: No

Hours: M-Th 8am-5pm; F 8am-12pm; Sat-Sun On Call
Staff Languages: Spanish, Vietnamese
Hospital Privileges: Anaheim Regional Medical Center, Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center, Placentia-Linda Community

Paul J. Kim, M.D. | **Radiation Oncology** | **(All Ages)**
Precision Radiation Oncology
2895 Edinger Ave. | Tel: (949) 381-5800 | **CCS: No**
Tustin, CA 92780 | Fax: (949) 552-5152 | **CHDP: No**
CPSP: No

Hours: M-F 9am-5pm
Provider Languages: Korean
Hospital Privileges: Admit Provider

Sharon Do Lee, M.D. | **Radiation Oncology** | **(All Ages)**
Orange County Radiation Oncology Medical Group
1100 N. Tustin Ave., Suite A | Tel: (714) 835-8520 | **CCS: Yes**
Santa Ana, CA 92705 | Fax: (714) 835-3610 | **CHDP: No**
CPSP: No

Board Certified: N
Hours: M-F 8am-5pm
Provider Languages: Korean
Hospital Privileges: Orange County Global Medical Center, Fountain Valley Regional Hospital, Anahemin Regional Medical Center

2nd Address: 18111 Brookhurst St LI0300, Fountain Valley, CA 92708 | Tel: (714) 962-7100 | Fax: (714) 963-7600

3rd Address: 24302 Paseo de Valencia, Laguna Hills, CA 92653 | Tel: (949) 452-8880 | Fax: (949) 859-5980

Gerald Y. Ho, M.D. | **Rheumatology** | **18 years and older**
Arthritis and Osteoporosis Medical Center
5451 La Palma Ave., Suite 25
La Palma, CA 90623
Tel: (714) 670-1340
Fax: (714) 443-3780
CCS: Yes
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Spanish, Cantonese, Mandarin
Staff Languages: Spanish, Cantonese, Mandarin, Chinese, Korean, Vietnamese
Hospital Privileges: Alhambra Hospital Medical Center, Garfield Medical Center, La Palma Intercommunity Hospital, Anaheim Regional Medical Center

Justin Wu, D.O. | **Rheumatology** | **18 years and older**
Arthritis and Osteoporosis Medical Center
5451 La Palma Ave., Suite 25
La Palma, CA 90623
Tel: (714) 670-1340
Fax: (714) 443-3780
CCS: No
CHDP: No
CPSP: No

Board Certified: Y
Hours: M-F 8am-5pm
Provider Languages: Spanish, Cantonese, Mandarin
Staff Languages: Spanish, Cantonese, Mandarin, Chinese, Korean, Vietnamese
Hospital Privileges: La Palma Intercommunity Hospital, Anaheim Regional Medical Center, Alhambra Hospital Medical Center, Garfield Medical Center

Luisa F. Acosta, S.P. | **Speech Pathology** | **(All Ages)**
Bright Star Speech and Language Services
1401 North Tustin Avenue; Suite 270
Santa Ana, CA 92705-8644
Tel: (714) 730-7700
Fax: (714) 730-7766
CCS: No
CHDP: No
CPSP: No

Hours: M-F 8am-5:30pm; Sat 9am-1:30pm
Staff Languages: Spanish, Arabic, Vietnamese

Kym K N Asahara, S.L.P | **Speech Therapy** | **(All Ages)**
11360 183rd Street
Cerritos, CA 90703
Tel: (714)639-4900
CCS: Yes
CHDP: No
CPSP: No

Board Certified: No
Hours: M-F 7:30am-6pm

David Austin Dillon, SLP | **Speech Therapy** | **(All Ages)**
All Care Therapies
5806 Pacific Blvd.
Huntington Park, CA 90255
Tel: (818) 894-2273
Fax: (818) 357-2505

Board Certified: No
Hours: M-F:7am-7pm
Provider's Languages: Spanish, Armenian, Indian, Arabic, Farsi
Staff's Languages: Spanish, Armenian, Indian, Arabic, Farsi

Maria Obenhaus, SLP | **Speech Pathology**
1301 W. Providence Ave.
Orange, CA 92868
Tel: (714) 639-4990
Fax: (714) 744-3841

Board Certified: No
Hours: M-F 8am – 6pm
Staff's Languages: Spanish

Camille Frances Stewart, SLP | **Speech Therapy** | **(All Ages)**
All Care Therapies
4300 Long Beach Blvd, Ste 700
Long Beach, CA 90807
Tel: (877) 757-8353
Fax: (818) 357-2505

Board Certified: No
Hours: M-F:7am-7pm
Provider's Languages: Spanish, Armenian, Indian, Arabic, Farsi
Staff's Languages: Spanish, Armenian, Indian, Arabic, Farsi

Reginald G.M. Abraham, M.D. | **Thoracic Surgery/ Cardiovascular Surgery** | **(18 years and older)**
11100 Warner Ave., Suite 258 | Tel: (714) 549-5990
Fountain Valley, CA 92708 | Fax: (714) 845-0041

Board Certified: Y
Hours: M, T, Th, F 9am-4pm; W 9am-12pm
Provider Languages: French, Spanish, Tamil, Chinese, Malay
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial

Naveen M. Dhar, M.D. | **Thoracic Surgery** | **(18 years and older)**
12665 Garden Grove Blvd., Suite 614 | Tel: (714) 530-5070
Garden Grove, CA 92843 | Fax: (714) 530-2465
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-5pm | **CPSP: No**
Provider Languages: Hindi, Urdu
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, South Coast Global Medical Center, Anaheim Regional Medical Center

Sridhara K. Iyengar, M.D. | **Thoracic Surgery** | **(18 years and older)**
11100 Warner Ave., Suite 320 | Tel: (714) 549-1294
Fountain Valley, CA 92708 | Fax: (714) 549-1296
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 8:30am-4pm | **CPSP: No**
Languages: Arabic, Farsi, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Anaheim Global Medical Center, Anaheim Regional Medical Center

Richard A. Ott, M.D. | **Thoracic Surgery** | **(18 years and older)**
1310 W. Stewart Dr., Suite 502 | Tel: (714) 774-1102
Orange, CA 92868 | Fax: (949) 459-0100
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-12pm | **CPSP: No**
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, St. Joseph Hospital-Orange, Orange County Global Medical Center, Anaheim Regional Medical Center, UCI Medical Center

Syam P. Vunnamadala, M.D. | **Thoracic Surgery** | **(18 years and older)**
Vascular Surgery
1211 W. La Palma Ave., Suite 310 | Tel: (714) 491-3928 | **CCS: No**
Anaheim, CA 92801 | Fax: (714) 491-3960 | **CHDP: No**
CPSP: No

Board Certified: General Surgey Only
Hours: M-F 8am-4pm
Provider Languages: Hindi, Telugu
Staff Languages: Arabic
Hospital Privileges: West Anaheim Medical Center, Orange County Global Medical Center, Anaheim Global Medical Center

Shlomi Albert, M.D. | **Urology** | **(14 years and older)**
11160 Warner Ave., Suite 423 | Tel: (714) 549-3333
Fountain Valley, CA 92708 | Fax: (714) 549-3334
CCS: No
Board Certified: Y | **CHDP: No**
Hours: M-F 9am-5pm | **CPSP: No**
Provider Languages: Hebrew
Staff Languages: Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

Khaled Fareed, M.D. | **Urology** | **All Ages**
Urology Center of OC
11100 Warner Ave., Suite 206 | Tel: (714) 546-1121
Fountain Valley, CA 92708 | Fax: (714) 546-0428

Board Certified: Yes
Hours: M-F 8am-5pm
Hospital Privileges: Fountain Valley Hospital, Orange Coast Memorial Medical Center, Garden Grove Hospital, HOAG Hospital

Scott K. Yun, M.D. | **Urology** | **(All Ages)**
14350 Whittier Blvd. Suite 100 | Tel: (562) 907-7600 | **ECHP ONLY**
Whittier, CA 90605 | Fax: (562) 907-7602

Board Certified: Y | **CCS: No**
Hours: M-F 8:30am-6pm | **CHDP: No**
Provider Languages: Korean | **CPSP: No**
Staff Languages: Spanish
Hospital Privileges: Presbyterian Intercommunity Hospital

Son T. Duong, M.D. | **Vascular Surgery** | **(All Ages)**
Orange County Vascular & Endovascular Surgery Center
11190 Warner Ave., Suite 408 | Tel: (714) 430-1414 | **CCS: No**
Fountain Valley, CA 92708 | Fax: (714) 430-1486 | **CHDP: No**
CPSP: No

Board Certified: Y
Hours: M-F 9am-5pm
Provider Languages: Vietnamese
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Hospital & Medical Center, Orange Coast Memorial Medical Center

John Hewett, M.D. | **Vascular & Interventional Radiology** | **(All Ages)**
Pedes Orange County, Inc.
1400 Reynolds Ave., Suite 110 | Tel: (949) 387-4724
Irvine, CA 92614 | Fax: (949) 209-0407

Board Certified: No
Hours: M-F 8am-5pm
Staff Languages: Vietnamese, Spanish
Hospital Privileges: Fountain Valley Regional Hospital, South Coast Global Medical Center

ANCILLARY CARE PROVIDERS

BEHAVIORAL HEALTH

Windstone Behavioral Health
151 Kalmus Dr., Suite K-1
Costa Mesa, CA 92626
Tel: (800) 577-4701
Fax: (714) 242-9512

CAPITATED LABORATORY

Lab Corp of America

Lab Corp
100 N. Tustin Ave.
Tustin, CA 92780
Tel: (714) 285-5916

Lab Corp
1122 West Washington Blvd, Suite 320
Los Angeles, CA 90015
Tel: (213) 741-0052

Lab Corp
23441 Madison St., Building 8, Suite 301
Torrance, CA 90505
Tel: (310) 303-3391

Lab Corp
23441 Madison St., Building 8, Suite 310
Torrance, CA 90505
Tel: (310) 406-3056

Lab Corp
2440 South Sepulveda Blvd., Suite 181
Los Angeles, CA 90064
Tel: (310) 996-6610

Lab Corp
605 East Huntington Drive, Suite 209
Monrovia, CA 91016
Tel: (626) 471-3500

Ambry Genetics
Genetic Testing ONLY **Pending Credentialing**
100 Columbia, Suite 200
Aliso Viejo, CA 92656
Anaheim, CA 92804
Tel: (949) 900-5507
Fax: (949) 900-5504

Myriad Genetics Labs
320 Wakara Way
Salt Lake City, UT 84108
Tel: (800) 469-7423

Natera, Inc.
201 Industrial Road, Suite 410
San Carlos, CA 94070
Tel: (650) 249-9090
Fax: (650) 730-2274

Dietitian:

JetSet Dietitian
1044 S. Fair Oaks Ave.
Pasadena, CA 91105
Tel: (424) 259-3132
Fax: (626) 774-7988

DME:

Byram Healthcare (DME/Enteral and Specialty Formula) **CCS:** Yes
5302 Rancho Rd. Tel: (800) 552-2633
Huntington Beach, CA 92647 Fax: (800) 992-6331

Aero Mobility, Inc. (DME/Orthotic & Prosthetics)
1001 N. Weir Canyon Rd. Tel: (714) 835-1000
Anaheim, Hills, CA 92807 Fax: (714) 973-8387

Advanced Home Medical (Home Medical Equipment)
312 Paseo Tesoro Tel: (909) 444-2991
Walnut, CA 91789 Fax: (888) 518-7568
Mailing Address: 23785 Canyon Vista Ct.
Diamond Bar, CA 91765

Advanced Medical Rx, Inc. (DME/Pharmaceuticals/Injections) Tel: (626) 988-0818
9122 Valley Blvd. Fax: (626) 988-0607
Rosemead, Ca 91770

Advanced Pharmacy Solutions
26611 Cabot Rd., Suite B. Tel: (949) 348-7900
Laguna Hills, Ca 92653 Fax: (949) 348-7922

Advanced Respiratory, Inc. (DME & Medical Supplies)
1020 County Road F W Tel: (800) 426-4224
St. Paul, MN 55126-2910 Fax: (651) 234-1684

Advanced Sleep Medicine Services, Inc.
104 E. Olive Ave. Ste. 104 Tel: (877) 775-3377
Redlands, CA 92373 Fax: (877) 855-6227

ATG Designing Mobility, Inc., dba Numotion
12627 Hidden Creek Way Tel: (562) 921-0258
Cerritos, CA 90703 Fax: (562) 921-3730

Elixair Medical, Inc.
12035 Burke St., Suite 13 Tel: (800) 354-9247
Santa Fe Springs, CA 90670 Fax: (877) 354-9247

Family Pharmacy
Rakesh Patel
1400 Atlantic Ave. Tel: (562) 591-4417
Long Beach, CA 90713 Fax: (562) 591-0416

Homedical, Inc.
15451 Red Hill Ave., Suite C. Tel: (714) 438-2230
Tustin, CA 92780 Fax: (714) 438-2233

National City and Mobility, Inc.
1125 East Stanford Court Tel: (714) 939-9322
Anaheim, CA 92805 Fax: (714) 939-9323

2nd Location
1210 E. 223rd Street, Suite 322 Tel: (844) 750-4168
Carson, CA 90754 Fax: (844) 750-4169

3rd Location
21807 Plumer Street Tel: (818) 718-1771
Chatsworth, CA 91311 Fax: (818) 718-1662

4th Location
350 Alabama St., Suite C&D Tel: (909) 335-6047
Redlands, CA 92373 Fax: (909) 798-4907

Premier Infusion Care Pharmacy
19500 Normandie Ave.
Torrance, CA 90502
Tel: (310) 328-389
Fax: (310) 328-6669

Rocco Pharmacy
1491 E. La Palma Ave., Suite A
Anaheim, CA 92805
Tel: (714) 603-7972
Fax: (714) 603-7992

Rosa Pharmacy (DME)
9200 Valley Blvd.
Rosemead, CA 91770
Tel: (626) 571-7672
Fax: (626) 571-7679

RX Consultants Group, Inc.
2010 E. First Street., Suite 120
Santa Ana, CA 92705
Tel: (714) 954-1902
Fax: (714) 954-1904

SuperCare, Inc.
16017 Valley Blvd.
City of Industry, CA 91744
Tel: (800) 206-4880
Fax: (626) 854-2285

Western Drug Medical Supply (Home Medical Equipment)
3604 San Fernando Rd.
Glendale, CA 91204
Tel: (818) 956-6691
Fax: (818) 956-6695

Providence Speech and Hearing Center Locations:

Providence Speech and Hearing – Cerritos - (All Ages)
11360 183rd Ste, Cerritos, CA 90703
Tel: (562) 809-2167 Fax: (562) 809-8497
Hours of Operation:
Monday - Friday: 8:00 AM - 6:00 PM

Providence Speech and Hearing – Fountain Valley- (All Ages)
17075 Bushard St., Fountain Valley, CA 92708
Tel: (714) 964-9277 Fax: (714) 962-4159
Hours of Operation:
Monday -- Friday: 8:00 AM - 6:00 PM
Saturday: 8:00 AM - 1:00 PM

Providence Speech and Hearing - Fullerton - (All Ages)
680 Langsdorf Drive, Suite 110, Fullerton, CA 92831
Tel: (714) 579-3204 Fax: (714) 579-0729
Hours of Operation:
Monday - Friday: 9:00 AM - 6:00PM

Providence Speech and Hearing – Garden Grove - (All Ages)
12881 Knott St, Suite 103, Garden Grove, CA 92841
Tel: (714) 892-6828 Fax: (714) 898-9720
Hours of Operation:
Monday - Friday: 8:00AM-6:00PM

Providence Speech and Hearing – Huntington Beach- (All Ages)
19582 Beach Blvd., Suite 110 Huntington Beach, CA 92648
Tel: (714) 602-2790 Fax: (714) 602-2791
Hours of Operation:
Monday - Friday: 8:30 AM - 5:00 PM

Providence Speech and Hearing – Mission Viejo - (All Ages)
23361 Madero, Suite 150, Mission Viejo, CA 92691
Tel: (949) 581-8239 Fax: (949) 599-0239
Hours of Operation:
Monday – Friday: 8:00 AM - 6:00 PM

Providence Speech and Hearing – Newport Beach - (All Ages)
520 Superior Ave., Suite 190 Newport Beach, CA 92663
Tel: (949) 548-0352 Fax: (949) 548-4839
Hours of Operation:
Monday - Friday: 8:00AM - 5:00PM

Providence Speech and Hearing – Orange - (All Ages)
1310 W. Providence Ave., Orange, CA 92868
Tel: (714) 639-4990 Fax: (714) 744-3841
Hours of Operation:
Monday - Friday 7:30AM – 6:00PM
Saturday: Appointment Only

CHOC Thompson Autism Center - (Ages 0-18 years)
170 S. Main St., Orange, CA 92868
Tel: (714) 288-7651 Fax: (714) 288-7379
Hours of Operation:
Monday - Friday: 8:00AM – 5:00PM

Word & Brown Hearing Center – Orange 2 - (All Ages)
1310 West Stewart Dr., Orange, CA 92868
Tel: (714) 639-4991 Fax: (714) 221-0978
Hours of Operation:
Monday - Friday: 7:30AM - 6:00pm

All Providence Speech and Hearing providers are linked to all service locations listed above

Provider Name	Specialty
Jenise I Chappell, AUD	Audiologist – CCS: NO
Allison Hong, AUD	Audiologist – IN PROCESS
Lanchi V Kim, AUD	Audiologist – IN PROCESS
Steve J Liu, AUD	Audiologist – IN PROCESS
Laura S Rhee, AUD	Audiologist – IN PROCESS
Chloe E Robbins, AUD	Audiologist – IN PROCESS
Kimberly A Schatz, AUD	Audiologist – IN PROCESS
Sarah M Shin, AUD	Audiologist – IN PROCESS
James C Townsley, AUD	Audiologist – IN PROCESS
Janis S Uffenheimer, AUD	Audiologist – IN PROCESS
Valerie M Guzzo, AUD	Audiologist – IN PROCESS

Provider Name	Specialty
Annie Chen, OT	Occupational Therapist – IN PROCESS
Lisa A Cummings, OT	Occupational Therapist – IN PROCESS
Manjiri J Gokhale, OT	Occupational Therapist – IN PROCESS
Nicole U Ngo, OT	Occupational Therapist – IN PROCESS
Darcy E Stevens, OT	Occupational Therapist – IN PROCESS
Kym K Asahara, SLP	Speech Language Pathologist
Stacie C Bateman, SLP	Speech Language Pathologist – CCS: YES
Robyn L Belz, SLP	Speech Language Pathologist - CCS: YES

Provider Name	Specialty
Jessica R Conod, SLP	Speech Language Pathologist – IN PRO
Christine Constantino, SLP	Speech Language Pathologist – CCS: YES
Zahra Jafarian-Blourchian, SLP	Speech Language Pathologist – IN PRO
Siera L Damian, SLP	Speech Language Pathologist – IN PRO
Megan J Dorsett, SLP	Speech Language Pathologist – IN PRO
Vivian M Figueroa, SLP	Speech Language Pathologist – IN PRO
Phyllis N Herring, SLP	Speech Language Pathologist – CCS: YES

Provider Name	Specialty
Samantha L McComb, SLP	Speech Language Pathologist
Celeste C Pepitone, SLP	Speech Language Pathologist – IN PRO
Danette C Salas, SLP	Speech Language Pathologist – CCS - YES
Le Etta Vanderpool, SLP	Speech Language Pathologist – IN PRO
Cynthia C Walsh, SLP	Speech Language Pathologist – IN PRO
Kristi L. N. Williams, SLP	Speech Language Pathologist – IN PRO

Serendipity Hearing Inc. dba Sonus Hearing Care, Sonus, the Hearing Spot (DME)

Los Angeles County Locations

2530 Atlantic Ave. Ste. D.
Long Beach, CA 90806
Tel: (562) 426-2137
Fax: (562) 426-2512

3816 Woodruff Ave. Ste. 305
Long Beach, CA 90808
Tel: (562) 982-0050
Fax: (562) 982-0052

8409 Pioneer Blvd.
Whittier, CA 90606
Tel: (562) 693-0703
Fax: (562) 692-0596

10929 South St. Ste. 202-B
Cerritos, CA 90703
Tel: (562) 860-1504
Fax: (562) 860-5713

Orange County Location

11180 Warner Ave. Ste. 263
Fountain Valley, CA 92708
Tel: (714) 378-1000
Fax: 714) 432-9389

2999 Westminster Ave. Ste. 104
Seal Beach, CA 90740
Tel: (562) 431-4314
Fax: (562) 431-4305

23685 Moulton Pkwy, Ste. B-1
Laguna Hills, CA 92653
Tel: (949) 587-9935
Fax: (949) 587-0486

4482 Barranca Pkwy, Ste. 175
Irvine, CA 92604
Tel: (949) 262-7190
Fax: (949) 262-7193

904 W. Town & Country Rd. Bldg. F
Orange, CA 92868
Tel: (714) 558-2666
Fax: (714) 558-7564

Health Homes

The Illumination Foundation

Accredited Home Health Services

5955 De Soto Ave, Suite 16
Woodland Hills, CA 92626
Tel: (714) 973-1234
Fax: (714)289-2867

HOSPICE

Hospice of Orange County Inc dba Butterfly Hospice Care **Pending Approval**

1440 N. Harbor Blvd., Suite 305A
Fullerton, CA 92835
Tel: (714) 587-9077
Fax: (833) 934-1559

PHARMACY SERVICES FOR PROVIDER OFFICE & SNF

Preferred Excellent Care

10521 Garden Grove Blvd.
Garden Grove, CA 92840
Tel: (714) 590-3620
Fax: (714) 590-3628

PHYSICAL/OCCUPATIONAL/SPEECH THERAPY

Active Sports Rehab and Wellness

6850 Lincoln Ave., Suite 205
Buena Park, CA 90620
Tel: (714) 527-9240
Fax: (714) 527-9230
Hours: M, W, F 9am-6pm
Staff Languages: Spanish, Tagalog

13330 Norwalk Blvd., Suite 101
Norwalk, CA 90650
Tel: (562) 484-3860
Fax: (562) 484-3861
Hours: M-F 9am-6pm
Staff Languages: Spanish, Tagalog

Cranial Technologies Inc.

1010 West La Veta Dr., Suite 510
Orange, CA 92868

Tel: (714) 834-9598
Fax: (714) 834-0135

Human Designs Prosthetic & Orthotic Laboratory, Inc.

2933 Long Beach Blvd.
Long Beach, CA 90806
Tel: (562) 988-2414
Fax: (562) 490-2831

49 E. Foothill Blvd.
Arcadia, CA 91006
Tel: (626) 445-7797
Fax: (626) 445-7873

1541 Parkway Loop, Suite C
Tustin, CA 92780
Tel: (714) 258-8144
Fax: (714) 258-8140

Quality Care Prosthetics and Orthotics

CCS: Yes

1665 W. Katella Ave.
Anaheim, CA 92801

Tel: (714) 643-9206
Fax: (714) 643-9467

RADIOLOGY (X-Ray, Ultrasounds, Mammography)

UNITED MEDICAL IMAGING HEALTHCARE — CAPITATED

Los Angeles County Locations

Downey:	11411 Brookshire Ave., Suite 101 Downey, CA 90241	Tel: (562) 869-9192 Fax: (562) 923-1604
Maywood:	4316 Slauson Ave. Maywood, CA 90270	Tel: (323) 374-6200 Fax: (323) 771-6094
Torrance:	3640 Lomita Blvd., Suite 105 Torrance, CA 90505	Tel: (310) 802-7000 Fax: (310) 375-8659
Long Beach:	701 E. 28th St., Suite 318 Long Beach, CA 90813	Tel: (562) 426-7000 Fax: (562) 426-7099
Los Angeles:	1127 Wilshire Blvd., Suite 100 Los Angeles, CA 90017	Tel: (213) 223-5000 Fax: (213) 202-5709
Minoo Heikali Women's Center of Los Angeles	1127 Wilshire Blvd, Suite 202 Los Angeles, CA 90017	Tel: (213) 223-5050 Fax: (213) 223-5098
Century City:	2080 Century Park East, Suite 104 Los Angeles, CA 90067	Tel: (310) 432-8000 Fax: (310) 432-8019
Inglewood:	110 S. La Brea Ave., Suite 150 Inglewood, CA 90301	Tel: (310) 671-6000 Fax: (310) 671-6302
East Los Angeles:	3513 Whittier Blvd. Los Angeles, CA 90023	Tel: (323) 859-8000 Fax: (323) 262-1699
Gardena:	1141 Redondo Beach Blvd., Suite 105 Gardena, CA 90247	Tel: (310) 436-1730 Fax: (310) 436-1731
Northridge:	18250 Roscoe Blvd., Ste 135 Northridge, CA 91325	Tel: (818) 701-7111 Fax: (818) 701-7841

South Long Beach:	1040 Elm Ave., Ste 102 Long Beach, CA 90813	Tel: (562) 285-1000 Fax: (562) 285-1019
Lynwood:	3737 Martin Luther King Jr. Blvd. Suite 104 Lynwood, CA 90262	Tel: (310) 554-1000 Fax: (310) 667-4998

Orange County Locations

Huntington Beach:	16161 Gothard St., Suite C Huntington Beach, CA 92647	Tel: (714) 843-6255 Fax: (714) 842-6957
Fountain Valley:	11160 Warner Ave., Suite 105 Fountain Valley, CA 92708	Tel: (714) 619-7500 Fax: (714) 619-7599
Garden Grove:	12665 Garden Grove Blvd., Suite 103 Garden Grove, CA 92843	Tel: (714) 620-8200 Fax: (714) 620-8211
Buena Park:	6131 Orangethorpe Ave., Suite 130 Buena Park, CA 90620	Tel: (714) 522-2077 Fax: (714) 522-2474
Brea:	375 W. Central Ave., Suite A Brea, CA 92821	Tel: (714) 482-2121 Fax: (714) 482-2120
Irvine:	15825 Laguna Canyon Rd., Suite 101 Irvine, CA 92618	Tel: (949) 777-9000 Fax: (949) 777-9007
Anaheim:	1801 W. Romneya Dr., Suite 104 Anaheim, CA 92801	Tel: (714) 678-4000 Fax: (714) 678-4022
Santa Ana:	800 N. Tustin Ave., Suite M Santa Ana, CA 90813	Tel: (714) 450-1410 Fax: (714) 450-1429

RESPITE/CAREGIVER RELIEF

CALOPTIMA ONECARE ONLY

Accredited Nursing Care

950 S. Coast Dr., Suite 215
Costa Mesa, CA 92626

Tel: (714) 973-1234
Fax: (714) 289-2867

SLEEP CENTERS (DIAGNOSTIC)

Fountain Valley Regional Sleep Center

17150 Euclid St., Suite 300
Fountain Valley, CA 92708

Tel: (714) 427-5900
Fax: (714) 427-5907

Miller Children's Subspecialty Group

Allergy & Asthma Care Center of Southern California Tax ID 33-0360328 (ALLERGY)

3816 Woodruff Ave., #209 Long Beach, Ca 90806 (562) 496-4749

	NPI	*CAQH*	
Steve Meltzer, MD	1316915135		

Pacific Cardiovascular Associates Tax ID 33-0618095 (CARDIOLOGY)

3080 Bristol St., #600 Costa Mesa, CA 92626 Tel. (714) 445-0220 Fax.(714) 445-0245

	NPI	*CAQH*	
Christopher Tan, MD	1912902602	11213408	
Dominic Blurton, MD	1750301230	11503879	
Yuliya Turiy, MD	1306088018	12208840	
Francesca Byrne, MD	1508023425	12441528	

Pediatric Critical Care Group of America Tax ID 71-1023888 (CRITICAL CARE) HOSPITAL BASED

2801 Atlantic Ave., Long Beach, CA 90806 TEL. (562) 933-8743 FAX. (562) 933-8744

	NPI	*CAQH*	
Carlos Maggi, MD	1437251147	11885208	
Christopher Babbitt, MD	1912009697	12310817	
Glenn Levine, MD	1003927195	11885212	
Kevin O'Brien, MD	1760444731	11885213	

South Counties Pediatric Critical Care Medical Group Tax ID 33-0871370 (CRITICAL CARE) HOSPITAL BASED

17100 Euclid St., Fountain Valley, CA 92708 Tel. (714) 966-7253 Fax. (562) 933-0026

	NPI	*CAQH*	
Alireza Fathi, MD	1992807523	11350696	
Marco Auylo, MD	1942592159	13579852	
Kenneth Kim, MD	1922002468	11315169	
Maria Elena Imperial, MD	1659476984	10589866	
Mundi Attinasi, MD	1790876282	12067284	
Roshan Cooray, MD	1457778706	14049278	
Tuan Nguyen, MD	1881023034		
Chi Troung, MD	1649262718	11506071	
William Perkins, MD	1699779181	10966978	
Zacharia Reda, MD	1487658936	10968553	
Natalie Darro, DO	1083976716	14238512	START 9/1/2018
Connie Hong, MD	1962889964	14270719	START 9/1/2018

Pediatric Sleep, Adoption and Developmental Clinic, Inc. Tax ID 39-2067578 (DEVELOPMENTAL MEDICINE)

2650 Elm Ave., #301 Long Beach, CA 90806 Tel. (562) 728-5034 FAX (562)-490-9413

11 Mareblu, Suite 200, Aliso Viejo, CA 92656 Tel (949) 446-8990 Fax (949) 446-8535 (O.C. office)

	NPI	*CAQH*	
Gary Feldman, MD	1740450378	11643570	
Robert Lebby, MD	1457344129		START 7/1/2018

California Sleep Neurology Organization for Wellness, P.C. Tax ID 81-5397988 (CRANIOFACIAL)

2651 Elm Ave #205 Long Beach, CA 90806 Tel. (562) 728-5034 Fax. (562) 728-5051

	NPI	*CAQH*	
Monika Mathur, MD	1265946586		

Pediatric Endocrinology Associates Tax ID 33-0079980 (ENDOCRINOLOGY)

2650 Elm Ave., #210 Long Beach, CA 90806 TEL. (562) 595-0166 FAX (562) 595-6714

	NPI	*CAQH*	
Mario Brakin, MD	1215921028	11413626	
Pablito Nagpala, MD	1306820071	12646486	

Children's Gastroenterology MCSG Tax ID 26-4220183 (GASTROENTEROLOGY)

1760 Termino Ave., #300 Long Beach, CA 90804 TEL. (562) 933-6900 Fax. (562) 933-0026

	NPI	*CAQH*	
Sarah Sela-Herman, MD	1710075502	10971413	
Leon, Chen, MD	1801194873	13899170	
Sonia Michail, MD	1629034665	17096060	
Roy Nattiv, MD	1023313772	13879663	
Stephanie Abrams, MD	1427160076	12743260	

Pediatric Gastroenterology Associates of Southern California Tax ID 94-3454578 (GASTROENTEROLOGY)			
1760 Termino Ave., #300 Long Beach, CA 90804 Tel. (562) 933-6900 Fax. (562) 933-8557			
	NPI	*CAQH*	
Anjuli Kumar, MD	1720102197	12097993	
Barry Steinmetz, MD	1003904814	10973673	
Malinda, Lin, MD	1295055457	12405615	
Mini Mehra, MD	1497869770	10962840	
Robert Tran, MD	1265515704	11499205	
Pediatric Infectious Disease Associates Medical Group Tax ID 33-0310813 (INFECTIOUS DISEASE/H.I.V.)			
2865 Atlantic Avenue, Suite 152, Long Beach, CA 90806 (562) 933-8590 Fax. (562) 933-0026			
	NPI	*CAQH*	
Audra Deveikis, MD	1558461327		
Pediatric Infectology Group Tax ID 47-4273757 (INFECTIOUS DISEASE/H.I.V.)			
2865 Atlantic Avenue, Suite 152, Long Beach, CA 90806 Tel.(562) 933-8590 Fax. (562) 933-0026			
Mail to: P.O. Box 92454, Long Beach, CA 90809-2454 e. longbeachPIG@gmail.com			
	NPI	*CAQH*	
Tempe Chen, MD	1043368863	13648331	
Jagmohan Batra, MD	1801936844	10788312	
Chris Anna Mink, MD	1598707192	10963473	START 3/1/2018
David Michalik, DO	1194842344	13633696	
Pediatric Hospitalist of America, Inc. Tax ID 47-0955911 (HOSPITALIST)			**HOSPITAL BASED**
2801 Atlantic Ave., Long Beach, CA 90806 TEL. (562) 933-8743 FAX. (562) 933-8744			
	NPI	*CAQH*	
Carlos Maggi, MD	1437251147	11885208	
Steve Jensen, MD	1083725196	10955931	
~~Tracy Clark, MD~~	~~1629140686~~	~~13544125~~	~~TERM 02/10/2019~~
Pediatric Medical Center Tax ID 95-2136288 (HOSPITALIST)			**HOSPITAL BASED**
2921 Redondo Ave., Long Beach, CA 90806 TEL. (562) 426-5551			
	NPI	*CAQH*	
Nicolas Ripp, MD	1740547744		
Lorston, MD	1356558191		
Louis Theriot, MD	1245386358		
Brenda Singh, MD	1437261831		
Peter Welty, MD	1356497226		
Pediatric Renal Medical Corp Tax ID 54-2145379 (NEPHROLOGY)			
2801 Atlantic Ave Long Beach, CA 90806 TEL. (562) 933-8528 FAX (562) 988-3028			
	NPI	*CAQH*	
Deepak Rajpoot, MD	1790734648	11459775	
Rumina Zaman, MD	1366616187	12763126	
Adult & Child Neurology Medical Associates Tax ID 33-0822857 (NEUROLOGY)			
2880 Atlantic Ave., #260 Long Beach, CA 90806 TEL. (562) 490-3580 FAX (562) 490-3584			
	NPI	*CAQH*	
Jean Lake, MD	1386686673	10958877	
Nicole Cobo, MD	1497954119	12554558	
Jasmin Dao, MD	1164811568		START 8/1/2018
Mary Kay Dyes, MD	1891737219	13728096	
Thanh Le, MD	1134165350	13722353	
Long Beach Neurological Medical Group Tax ID 95-2741706 (NEUROLOGY)			
2880 Atlantic Ave., #260 Long Beach, CA 90806 (562) 426-3319 FAX (562) 490-3584			
	NPI	*CAQH*	
Perry Lubens, MD	1659385664	10961009	
Family Eye Medical Group Tax ID 94-2595477 (OPHTHAMOLOGY)			
4100 Long Beach Blvd., Long Beach, CA 90809 TEL. (562) 426-3925 FAX (562) 595-7638			
	NPI	*CAQH*	
Andrew Choy, MD	1871513168	10945731	
Ajay Manchandia, MD	1720243082	12583593	
Robert Clark, MD	1043232325	10945979	
Teresa Rosales, MD	1851314520	10945731	
Veronique Jotterand, MD Medical Corp. Tax ID 33-0733048 (OPHTHAMOLOGY)			
2865 Atlantic Ave., #109 Long Beach, CA 90806 Tel. (562) 988-2020 Fax. (562) 426-7394			
	NPI	*CAQH*	
Veronique Jotterand, MD	1083636187		



Tichenor Lowman MIller Medical Group Tax ID 33-0724908 (ORTHOPEDICS)			
1760 Termino Ave., #308 Long Beach, CA 90804 Tel. (562) 933-0249 Fax. (562) 933-3747			
	NPI	*CAQH*	
Emory Chang, MD	1962593962	11631603	
John Hajaliloo, MD	1780674507	11193721	
Torin Cunningham, MD	1861436891	11465850	
Anna Marie Acosta, MD	1285933424		START 8/1/2018
Kenneth Huh, MD	1861664849	12433086	
Amy Williams, MD	1871881458	13696161	
F. John Hajaliloo, MD Tax ID 54-2132096 (ORTHOPEDICS)			
2840 Long Beach Blvd. # 440, Long Beach, CA 90806 Tel. (562) 595-6646 Fax. (562) 490-0434			
	NPI	*CAQH*	
John Hajaliloo, MD	1780674507	11193721	
Southern California Ear, Nose & Throat Tax ID 52-2237905 (OTORHINOLARYNGOLGY)			
433 E Wardlow Rd., Long Beach, CA 90807 (562) 427-0550			
	NPI	*CAQH*	
Nina Yoshpe, MD	1952475691	11118292	
Namrata Varma, D.O.	1679703599	13643513	
Ayal Willner, MD	1548334295	10977842	
Kimberly BeDell, MD, Inc. Tax ID 95-4703143 (PHYSIATRY)			
2801 Atlantic Ave., Long Beach, CA 90806 Tel. (562) 933-8832 Fax. (562)-933-0026			
	NPI	*CAQH*	
Melanie Irwin, MD	1518918358		
Kimberly BeDell, MD	1063454486	10941976	
Sujin Lee, MD	1073829909		
A. Paul Kurkjian MD A Medical Corp. Tax ID 27-5560402 (PSYCHIATRY)			
2701 Atlantic Ave., #C Long Beach, CA 90806 Tel. (562)-933-8590 Fax. (562)-933-0026			
	NPI	*CAQH*	
A. Paul Kurkjian	1134334550	12004600	
Pediatric Pulmonary Associates, Inc. Tax ID 74-3135066 (PULMONOLOGY & IMMUNOLOGY)			
2801 Atlantic Ave., Long Beach, CA 90806 TEL. (562) 933-8567 FAX. (562) 933-8569			
	NPI	*CAQH*	
Terry Chin, MD	1811093305		Pulmonary
Eliezer Nussbaum, MD	1821194820		Pulmonary
Jen Jen, Chen, MD	1093027328		Pulmonary
Elizabeth Foley, MD	1649505538		Pulmonary
Cyrus Shahriary, MD	1316135106		Pulmonary
James Brock, DO	1871859611		START 7/12/2018 Pulmonary
Inderpal Randhawa, MD	1316035363		Pulm/Immun
Coast Urological Medical Group Tax ID 33-0378858 (UROLOGY)			
3771 Katella Avenue, suite 210, Los Alamitos, CA 90720			
	NPI	*CAQH*	
Michael Norris, MD	1114023850	13714227	

Revised 04.01.19

CHOC Children's Specialists

Physician Roster
TIN: 95-2321786
Group NPI:
1275975104
www.choc.org/specialis

PHYSICIAN NAME		SPECIALTY		
ALLERGY Phone (714) 633-6363 Fax (714) 633-0178			**LICENSE**	**NPI**
Chan, Wan-Yin	MD	Allergy/Immunology-Pediatric & Adult	A101604	1932391471
Dao, Anh	MD	Allergy/Immunology-Pediatric & Adult	A162446	1003176785
Ellis, Mark	MD	Allergy/Immunology-Pediatric & Adult	C41445	1568569424
Field, Sarah	MD	Allergy/Immunology-Pediatric & Adult	A121800	1053532366
CARDIOLOGY Phone (714) 509-3939 Fax (714) 509-3949			**LICENSE**	**NPI**
Batra, Anjan	MD	Cardiology	A61838	1558453258
Chang, Anthony	MD	Cardiology	G78374	1144328360
Doshi, Nita	MD	Cardiology	A92971	1891984316
Horenstein, Maria	MD	Cardiology	A87618	1760626352
Kiciman, Nafiz	MD	Cardiology	A49326	1083794259
Lai, Wyman	MD	Cardiology	A61378	1689659955
Mc Canta, Anthony	MD	Cardiology	A91217	1730277658
Morchi, Gira	MD	Cardiology	A103210	1386790996
Muhonen, Linda	MD	Cardiology	G63528	1891883708
Recto, Michael	MD	Cardiology	A55642	1013912674
Renella, Pierangelo	MD	Cardiology	A86410	1124117254
Sinha, Sanjay	MD	Cardiology	A125893	1881985349
Swensson, Richard	MD	Cardiology	C39805	1013912054
CARDIOTHORACIC SURGERY Phone (714) 997-2224 Fax (714) 997-1187			**LICENSE**	**NPI**
Gates, Richard	MD	Cardiothoracic Surgery	G70608	1568481414
Starr, Joanne P.	MD	Cardiothoracic Surgery	G88848	1720055163
CRITICAL CARE Phone (714) 509-8820 Fax (714) 509-4072			**LICENSE**	**NPI**
Cappon, James *	MD	Critical Care	G65846	1336232875
Cherin, Anthony *	MD	Critical Care	A71240	1831283837
Cook, Jason *	MD	Critical Care	A75756	1689775140
Domico, Michele *	MD	Critical Care	A83525	1932305000
Guardenier, Andrea*	MD	Critical Care	A126103	1881731909
Goodman, Gary *	MD	Critical Care	G45219	1588758551
Hunt, Juliette *	MD	Critical Care	A121438	1265615389
Iwai, Dina *	MD	Critical Care	A71762	1164516944
Jalili, Mehrdad *	MD	Critical Care	A44450	1811077084
Kar, Renuka*	MD	Critical Care- Hospitalist	A118234	1144530932
Kassir, Kari *	MD	Critical Care	A55576	1174617831
Kelly, Robert	MD	Critical Care	A91532	1134307713
Knight, Jason *	MD	Critical Care	A70791	1437243102
Liao, Patricia *	MD	Critical Care	A85514	1972792877
Liu, Paul H.*	MD	Critical Care	G150410	1548233018
Lubinsky, Paul *	MD	Critical Care	A41539	1255427076
McMenaman, Kathrn S.*	DO	Critical Care	20A13050	1770849416
Nguyen-Tang, Hanh-Uyen *	MD	Pediatrics	A99280	1851588156
Schwarz, Adam J *	MD	Critical Care	G72779	1194797951
Umnas, Gilbert G*	MD	Pediatrics	A64719	1043306863
Yu, Regina D*	DO	Critical Care-Hospitalists	20A17199	1679969232
Zabrocki, Luke A*	MD	Critical Care	C128210	1992765796
DEVELOPMENTAL-BEHAVIORAL Appointments (888) 770-2462 Fax (855) 246-2329			**LICENSE**	**NPI**
Chung, Peter J.,	MD	Developmental-Behavioral	A108088	1083813687
Steinberg-Epstein, Robin B.	MD	Developmental-Behavioral	G81135	1760562904

Grover, Geeta	MD	Developmental-Behavioral	G67016	1508901927
ENDOCRINOLOGY Phone (714) 509-8634 Fax (714) 509-3300 Appointments (888) 770-2462			**LICENSE**	**NPI**
Bhangoo, Amrit	MD	Endocrinology	A119707	1982882254
Daniels, Mark	MD	Endocrinology	A63018	1568552651
Dreimane, Daina	MD	Endocrinology	A56108	1013098177
Flannery, Timothy	MD	Endocrinology	G72809	1871662304
Forghani, Nikta	MD	Endocrinology	A82286	1902011026
Kadakia, Sejal	MD	Endocrinology	A124680	1952692089
Kashmiri, Himala	DO	Endocrinology	20A14189	1386808285
Polgreen, Lynda E.	MD	Endocrinology	C133183	1679617930
Reh, Christina	MD	Endocrinology	A94219	1255579371
Trinh, Lien	MD	Endocrinology	A87921	1518082304
GASTROENTEROLOGY Phone (714) 509-4099 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Chogle, Ashish	MD	Gastroenterology	C134863	1023273141
Grant, Kenneth	MD	Gastroenterology	G60289	1154414225
Ho, Jeffrey	DO	Gastroenterology	20A9990	1003932963
Idries, Shaheen	MD	Gastroenterology	A50795	1194812263
Katz, Mitchell	MD	Gastroenterology	G46842	1366530107
Patel, Anup	MD	Gastroenterology	A95015	1215015888
Silva, Kimberly	MD	Gastroenterology	A116974	1871891606
Wang, Michael	DO	Gastroenterology	20A15556	1124373683
Wong, Gregory	MD	Gastroenterology	A124939	1386977288
Younes, Bassam	MD	Gastroenterology	A54854	1467521997
Yang, Christine	MD	Gastroenterology	A128725	1245630797
HEMATOLOGY Phone (714) 509-8459 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Buchbinder, David	MD	Hematology	A90272	1871734509
Hsieh, Loan B	MD	Hematology	A82088	1770774341
Hwang, Nina X.	MD	Hematology	A107879	1427286343
Mahajerian, Arash	MD	Hematology	A126238	1033315247
Nugent, Diane J	MD	Hematology	G75931	1770528663
Puthenveetil, Geetha	MD	Hematology	A72517	1174626683
Salinas Luna, Vanessa K.	MD	Hematology	A107215	1952597858
Soni, Amit	MD	Hematology	A86383	1659539211
Won, Eric H.	MD	Hematology	A134658	1497192710
HOSPITALIST* Phone (714) 509-8826 Fax (855) 246-2329			**LICENSE**	**NPI**
Afghani, Behnoosh *	MD	Hospitalist	G69511	1528148681
Andreeff, Katherine *	MD	Hospitalist	A81633	1295827939
Armstrong, Jeffrey *	MD	Hospitalist	G65001	1376641548
Bendig, Donald W*	MD	Hospitalist	G32198	1952409138
Brennan, Sarah*	MD	Hospitalist	A134033	1366887762
Chang, Kris*	DO	Hospitalist	20A18324	1770965956
Chin, Dayna*	MD	Hospitalist	A125962	1356631790
Golden, Charles*	MD	Hospitalist	20A9908	1821261124
Gorodetski, Svetlana *	MD	Hospitalist	A99376	1386814838
Lusk, Jennifer *	MD	Hospitalist	A108240	1235366337
Ho, Jennifer *	MD	Hospitalist	A107231	1801020144
Kang, Daniel *	MD	Hospitalist	A119615	1518264647
Mihalek, Alexandra J*	MD	Hospitalist	A146413	1528504578
Marano, Rachel*	MD	Hospitalist	A140825	1043673528

Panbehi, Bahman *	MD	Hospitalist	A111751	1245542125
Pathare, Sameer *	MD	Hospitalist	A80828	1750489951
Pechulis, Georgie *	MD	Hospitalist	A111809	1164748521
Todd, Dean*	MD	Hospitalist	A129120	1053673392
Totaro, Laura A. *	MD	Hospitalist	A125361	1760777197
Ulloa, Erin *	MD	Hospitalist	C147139	1922273580
Van, Chau Y.*	MD	Hospitalist	A132948	1396180758
Wang, Tommy *	MD	Hospitalist	A97518	1235300989
Winkelmann, Jacqueline *	MD	Hospitalist	A72934	1215026331
Wungwattana, Mink*	MD	Hospitalist	A128717	1558628552
INFECTIOUS DISEASE Phone (714) 509-8403 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Arrieta, Antonio	MD	Infectious Diseases	A46432	1861599748
Ashouri, Negar	MD	Infectious Diseases	A76007	1275630154
Cheung, Michele *	MD	Infectious Diseases	A63515	1467563551
Nieves, Delma	MD	Infectious Diseases	A87032	1083894315
Singh, Jasjit	MD	Infectious Diseases	G82074	1306915848
Zahn, Mathew *	MD	Infectious Diseases	C55094	1871577833
METABOLIC DISORDERS Phone (714) 509-8852 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Abdenur Jose	MD	Metabolic Disorders	A83870	1154428027
Chang, Richard	MD	Metabolic Disorders	A82661	1043317910
Chapel Crespo, Cristel	MD	Metabolic Disorders	A149700	1275821555
Wang, Raymond	MD	Metabolic Disorders	A80602	1508914458
NEONATOLOGY* Phone (714) 509-4373 Fax (714) 509-7800			**LICENSE**	**NPI**
Ahmad, Irfan*	MD	Neonatology	C51038	1699790139
Ansari, Aamir*	MD	Neonatology	C143102	1295918696
Arias-Shah, Anne Marie*	MD	Neonatology	A168184	1851731756
Arul, Nandini*	MD	Neonatology	A105945	1093737959
Ashrafi, Amir *	MD	Neonatology	A102155	1558548503
Aslam, Muhammad* (UCI)	MD	Neonatology	C56159	1346313590
Atif, Muzna *	MD	Neonatology	C144330	1396942413
Bany-Mohammad, Fayez* (UCI)	MD	Neonatology	A052053	1124108204
Bassiri, Daryoush*	MD	Neonatology	A75836	1154414639
Bhakta, Kushal *	MD	Neonatology	A92563	1952338063
Bixby, Christine*	MD	Neonatology	A81484	1184752610
Bruce, Kari G*	MD	Neonatology	A143346	1336584028
Chai, Edward*	MD	Neonatology	A85161	1700901337
Chundu, Anupama*	MD	Neonatology	A149505	1699181404
Cleary, John*	MD	Neonatology	G71413	1134213143
Coleman, Rebecca* (UCI)	MD	Neonatology	A84897	1023286101
Devarajan, Kamakshi*	MD	Neonatology	A55865	1386794741
Dhar, Vijay*	MD	Neonatology	A51629	1609951888
Flores-Fenlon, Nicole*	MD	Neonatology	A134731	1598102584
Golkarieh, Narsis*	MD	Neonatal-Hospitalist	A88808	1598865388
Halloran, Katrina*	MD	Neonatology	A141346	1598102584
Hanten, Stephen *	MD	Neonatology	A38921	1699869552
Haas, Sally*	MD	Neontaology	A83214	1245418201
Hicks, David*	MD	Neonatology	A26166	1851485627
Hillyard, Robert*	MD	Neonatology	G55855	1073607842

Hwang, Jung Sook (Stella)*	DO	Neonatology	20A13323	1235491580
Iqbal, Sameeia*	MD	Neonatology	A149751	1700291655
Jones, Sophia *	MD	Pediatrics	A88425	1184637308
Kadri, Munaf M.*	MD	Neonatology	A61215	1730102476
Kambestad, Kristi*	MD	Neonatology	A133828	1427493444
Kamran, Shahid *	MD	Neonatology	A50261	1093809741
Kar, Renuka*	MD	Neonatal-Hospitalist	A118234	1144530932
Kohen-Diniak, Carole*	DO	Pediatrics	20A15780	1740353614
Kim, David*	MD	Neonatology	A82018	1003001157
Krishnan, Ravi*	MD	Neonatology	C53892	1588640197
Kukreja, Sudeep*	MD	Neonatology	A43878	1356435051
Kurlawalla-Martinez, Christine *	MD	Neonatology	A72247	1205920931
LaFontaine, Diana*	MD	Neonatal-Hospitalist	A124100	1770874703
Lim, Jina*	MD	Neonatology	A121375	1992065361
Liu, Anthony*	MD	Neonatology	A77892	1891889531
Mikhael, Michel *	MD	Neonatology	A121295	1265629612
Milisavljevic, Vladana*	MD	Neonatology	A84271	1326065269
Mistry, Pankaj N * (Pomona Valley)	MD	Neonatology	A44860	1366518342
Morales, Gloria *	MD	Neonatology	A42269	1043358831
Nakai, Junko*	MD	Neonatal-Hospitalist	A110795	1205152006
Nichols, Scott A.,*	MD	Neonatology	C55854	1013903348
Nicolau, Yona* (UCI)	MD	Neonatology	A105019	1740437953
Nwafor-Anene, Victoria*	MD	Neonatology	A76135	1447423488
Oza, Dushyant*	MD	Neonatology	A34491	1538294889
Patel, Dilipkumar*	MD	Neonatology	A52224	1851480966
Patel, Devang *	MD	Neonatology	A91453	1609070994
Patel, Monalisa	MD	Neonatology	A129574	1831487461
Ramadan, Naglaa *	MD	Neonatology	A43529	1053427294
Rehan, Virender * (independent contractor)	MD	Neonatology	A68186	1659382539
Saesim, Daniel*	MD	Neonatology	A89265	1598880072
Saini, Hemant* (Apple Valley)	MD	Neonatology	A101942	1306833900
Shafer, Grant J*	MD	Neonatology	A169198	1831516764
Shah, Anita*	MD	Neonatology	A148191	1962727180
Sheng, Lavonne*	MD	Neonatology	A85563	1134246432
Sills, Jack*	MD	Neonatology	G43525	1528114774
Singh, Dalbir*	MD	Neonatology	C55579	1235269127
Singh, Harjinder. * (Pomona Valley)	MD	Neonatology	A46383	1407919004
Sondhi, Monica*	MD	Neonatology	A121010	1144456641
Sun, Wang-Dar *	MD	Neonatology	A98671	1891982377
Taylor, Sneha, MD*	MD	Neonatology	A125453	1841507431
Tesmer, Katarzyna*	MD	Neonatology	A53721	1679662753
Tran, John *	MD	Neonatology	A117003	1477780864
Uy, Cherry* (UCI)	MD	Neonatology	A53472	1730273095
Wickham, Lawrence *	MD	Neonatology	A29385	1982667820
Yaeger, Loren E*	DO	Neonatology	20A14451	1366826091
Zepeda-Tiscareno, Anne*	MD	Neonatology	A139974	1861898256
NEPHROLOGY Phone (714) 509-8324 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Narayan, Shoba	MD	Nephrology	A93828	1841516093
Nguyen, John	MD	Nephrology	A103212	1902006075

Ton, That Nam Tran (Sony)	MD	Nephrology	A140320	1366897274
Veiga, Patricia	MD	Nephrology	G70681	1982792602
Zaman, Rumina	MD	Nephrology	A98112	1366616187
NEUROLOGICAL SURGERY Phone (714) 509-7070 Fax (714) 509-7074			**LICENSE**	**NPI**
Loudon, William	MD	Neurosurgery	A72588	1437265816
Magge, Suresh N.	MD	Neurosurgery	C169686	1356404651
Muhonen, Michael	MD	Neurosurgery	G082059	1801804810
Olaya, Joffre	MD	Neurosurgery	A104640	1326255852
NEUROLOGY Phone (714) 509-7601 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Chen, Agnes	MD	Child Neurology	A80127	1902009418
Fernandez, Amanda	MD	Child Neurology	C50398	1770551350
Galion, Anjalee	MD	Child Neurology	A101608	1356500268
Ivy, Autumn S.	MD	Child Neurology	A126865	1659638666
Kayyal, Simon Y.	MD	Child Neurology	C161496	1700028735
Mathur, Monika G.	MD	Child Neurology	A120142	1558669002
Megerian, J.Thomas	MD	Neurology	G137941	1124065891
Pearson, Rachel P.	MD	Child Neurology	A140013	1386064020
Phillips, Donald	MD	Neurology, Epilepsy, Clinical Neurophysiology	A114716	1447485701
Prezkop, Allison A.	DO	Child Neurology	20A8670	1740493717
Sanger, Terence D.	MD	Child Neurology	G80612	1326036013
Skora, Clare E.	MD	Child Neurology	A161924	1902223373
Shrey, Daniel W.	MD	Child Neurology	A110337	1518129162
Steenari, Maija	MD	Child Neurology	A112054	1205157476
Taraman, Sharief	MD	Child Neurology	A116566	1013118454
Thomas, Julian M.	MD	Child Neurology	A137614	1003235607
Totoiu, Minodora	MD	Child Neurology	A98106	1235339656
Tournay, Anne (UCI)	MD	Child Neurology, Neurodevelopmental	A51284	1194819458
Tran, Lily	MD	Child Neurology	A118437	1487865523
Zupanc, Mary	MD	Child Neurology, Clinical Neurophysiology	G44563	1861444366
ONCOLOGY Phone (714) 509-4348 Fax (714) 509-8699			**LICENSE**	**NPI**
Abongwa, Chenue	MD	Oncology, Neurology	A135441	1417249319
Chavan, Rishikesh	MD	Oncology, Blood Marrow Transplant	C141227	1700058526
Frediani, Jamie	MD	Oncology	A131342	1447540505
HaDuong, Josephine	MD	Oncology	A99760	1780857573
Horvath, Agnes	MD	Oncology	A48541	1376682070
Huynh, Van	MD	Oncology	A93585	1538462080
Kirov, Ivan	MD	Oncology	A56138	1215025044
Lin, Carol	MD	Oncology	A107185	1053553347
Morris, Joan	MD	Oncology	G86530	1629183371
Neudorf, Steven	MD	Oncology	G85193	1598848624
Rubin, Elyssa	MD	Oncology	A88460	1578738282
Torno, Lilibeth	MD	Oncology	A50517	1235227943
Wang, Victor	MD	Oncology	A113969	1265776587
OPHTHALMOLOGY Phone (714) 289-2389 Fax (714) 289-2390			**LICENSE**	**NPI**
Bhola, Rahul	MD	Ophthalmology	C144757	1609910033
Manchandia, Ajay M	MD	Ophthalmology	A120510	1720243082
Weiss, Sidney	MD	Ophthalmology	G27151	1578584231
OTOLARYNGOLOGY Phone (714) 633-4020 Fax (714) 953-5462			**LICENSE**	**NPI**
Ahuja, Gurpreet	MD	Otolaryngology	A54475	1013970169

Bhatt, Jay	MD	Otolaryngology	A126898	1174880496
Chang, David T.	MD	Otolaryngology	A117677	1407172075
Huoh, Kevin	MD	Otolaryngology	A106715	1245471275
Pham, Nguyen	MD	Otolaryngology	A102823	1861661373
Zhong, Qiu	MD	Otolaryngology	A131645	1609185990
PEDIATRIC GENERAL & THORACIC SURGERY Phone (714) 364-4050 Fax (714) 364-4051			**LICENSE**	**NPI**
Awan, Saeed-Ur-Rehman	MD	Pediatric Surgery	C55769	1457691685
Gholizadeh, Maryam	MD	Pediatric Surgery	A83935	1194724583
Gibbs, David	MD	Pediatric Surgery	G79479	1467432609
Guner, Yigit S.	MD	Pediatric Surgery	A89069	1851375828
Kabeer, Mustafa	MD	Pediatric Surgery	G86862	1093795239
Reyna, Troy	MD	Pediatric Surgery	G87971	1659371581
Yu, Peter T.	MD	Pediatric Surgery	A100686	1215109004
PSYCHIATRY Phone (714) 509-8481 Fax (714) 509-8759 Appointments (888) 770-2462			**LICENSE**	**NPI**
Hwang, Michael S.	MD	Pediatric Psychiatry	A121559	1336382316
Lai, Laura	MD	Pediatric Psychiatry	A136143	1518300078
Nguyen, Hoang (Wanye)	MD	Pediatric Psychiatry	A69179	1841240769
Relia, Sachin	MD	Pediatric Psychiatry	A119785	1497989347
Suzuki, Alejanda	MD	Pediatric Psychiatry	A723229	1730213497
Yang, Esther	MD	Pediatric Psychiatry	A125272	1013208552
Wusirika, Lavanya	MD	Pediatric Psychiatry	A136831	1922441211
PULMONOLOGY Phone (714) 509-8622 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Chin, Chana	MD	Pulmonology	A112215	1033457270
Gage, Susan	MD	Pulmonology	A111459	1396060554
Hong, Hanna	MD	Pulmonology	A126707	1023364692
Kamath, Sunil	MD	Pulmonology	A100527	1194985002
Nakra, Neal K.	MD	Pulmonology- Sleep Medicine	C135395	1558561597
Tirakitsoontorn, Pornchai	MD	Pulmonology	A64929	1427085810
Yuengsrigul, Anchalee	MD	Pulmonology	A53260	1700972536
RADIOLOGY Phone (714) 509-9081 Fax (714) 509-9078 Appointments (888) 770-2462			**LICENSE**	**NPI**
Beydoun, Tammam	DO	Vascular & Interventional Radiology	20A14487	1033349014
Dao, Tuan*	MD	Pediatric & Diagnostic Radiology	A139553	1134354079
Eghbal, Azam*	MD	Pediatric & Diagnostic Radiology	C55958	1821097569
Lai, Hollie*	MD	Pediatric & Diagnostic Radiology	A62577	1124123609
Holmes, William (Nathan)*	MD	Pediatric & Diagnostic Radiology	A104831	1700811700
Bula, Melanie L* (ARIS)	MD	Pediatric & Diagnostic Radiology	A111302	1205152006
Chang, Johanna M* (ARIS)	MD	Pediatric & Diagnostic Radiology	A110028	1356570980
Craychee, Judith A* (ARIS)	MD	Pediatric & Diagnostic Radiology	G82280	1831198472
Galvez, Michelle A* (ARIS)	MD	Pediatric & Diagnostic Radiology	A122310	1043483175
Gyves-Ray, Katherine* (ARIS)	MD	Pediatric & Diagnostic Radiology	G88889	1578521811
Halabi, Safwan* (ARIS)	MD	Pediatric & Diagnostic Radiology	A105003	1669491320
Iqbal, Vassem* (ARIS)	MD	Pediatric & Diagnostic Radiology	G88289	1780655548
Katz, Michael* (ARIS)	MD	Pediatric & Diagnostic Radiology	G88982	1861463390
Machado, Sandra* (ARIS)	MD	Pediatric & Diagnostic Radiology	A109969	1265639710
Nahl, Daniel*	DO	Pediatric & Diagnostic Radiology	20A15315	1053672725
Sung, Andrew J.*	MD	Pediatric & Diagnostic Radiology	A138377	1265875561
RHEUMATOLOGY Phone (714) 509-8617 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Lim, Emilina	MD	Rheumatology	C141929	1235289273
Shulman, Andrew	MD	Rheumatology	A122794	1760649842

MISC. SERVICES			LICENSE	NPI
Irwin, Melanie C. Nicole **PH: (714) 835-2724**	MD	Physical Medicine & Rehabilitation	A99872	1518918358
Keating, Sarah L. **PH: (888) 770-2462**	MD	Hospice and Palliative Care Medicine	A141346	1831509421
Wong, Daphne **PH: (714) 509-8338**	MD	Child Abuse	A60029	1740291467
Triebwasser, Harvey S. **PH: (888) 770-2462**	MD	Adolescent Medicine	G20277	1144352840
Yonan, Terez **PH: (888) 770-2462**	MD	Adolescent Medicine	20A13412	1578853685
Roche, Alexandra **PH: (888) 770-2462**	MD	Adolescent Medicine	A94044	1164540126
Nassif, Nader **PH: (888) 770-2462**	MD	Orthopedic Surgery/Limb Salvage	A125009	1629262183
Olson, Douglas P. **PH: (888) 770-2462**	DMD	Orthodontics	DDS104517	1144369125

Ton, That Nam Tran (Sony)	MD	Nephrology	A140320	1366897274
Veiga, Patricia	MD	Nephrology	G70681	1982792602
Zaman, Rumina	MD	Nephrology	A98112	1366616187
NEUROLOGICAL SURGERY Phone (714) 509-7070 Fax (714) 509-7074			**LICENSE**	**NPI**
Loudon, William	MD	Neurosurgery	A72588	1437265816
Magge, Suresh N.	MD	Neurosurgery	C169686	1356404651
Muhonen, Michael	MD	Neurosurgery	G082059	1801804810
Olaya, Joffre	MD	Neurosurgery	A104640	1326255852
NEUROLOGY Phone (714) 509-7601 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Chen, Agnes	MD	Child Neurology	A80127	1902009418
Fernandez, Amanda	MD	Child Neurology	C50398	1770551350
Galion, Anjalee	MD	Child Neurology	A101608	1356500268
Ivy, Autumn S.	MD	Child Neurology	A126865	1659638666
Kayyal, Simon Y.	MD	Child Neurology	C161496	1700028735
Mathur, Monika G.	MD	Child Neurology	A120142	1558669002
Megerian, J.Thomas	MD	Neurology	G137941	1124065891
Pearson, Rachel P.	MD	Child Neurology	A140013	1386064020
Phillips, Donald	MD	Neurology, Epilepsy, Clinical Neurophysiology	A114716	1447485701
Prezkop, Allison A.	DO	Child Neurology	20A8670	1740493717
Sanger, Terence D.	MD	Child Neurology	G80612	1326036013
Skora, Clare E.	MD	Child Neurology	A161924	1902223373
Shrey, Daniel W.	MD	Child Neurology	A110337	1518129162
Steenari, Maija	MD	Child Neurology	A112054	1205157476
Taraman, Sharief	MD	Child Neurology	A116566	1013118454
Thomas, Julian M.	MD	Child Neurology	A137614	1003235607
Totoiu, Minodora	MD	Child Neurology	A98106	1235339656
Tournay, Anne (UCI)	MD	Child Neurology, Neurodevelopmental	A51284	1194819458
Tran, Lily	MD	Child Neurology	A118437	1487865523
Zupanc, Mary	MD	Child Neurology, Clinical Neurophysiology	G44563	1861444366
ONCOLOGY Phone (714) 509-4348 Fax (714) 509-8699			**LICENSE**	**NPI**
Abongwa, Chenue	MD	Oncology, Neurology	A135441	1417249319
Chavan, Rishikesh	MD	Oncology, Blood Marrow Transplant	C141227	1700058526
Frediani, Jamie	MD	Oncology	A131342	1447540505
HaDuong, Josephine	MD	Oncology	A99760	1780857573
Horvath, Agnes	MD	Oncology	A48541	1376682070
Huynh, Van	MD	Oncology	A93585	1538462080
Kirov, Ivan	MD	Oncology	A56138	1215025044
Lin, Carol	MD	Oncology	A107185	1053553347
Morris, Joan	MD	Oncology	G86530	1629183371
Neudorf, Steven	MD	Oncology	G85193	1598848624
Rubin, Elyssa	MD	Oncology	A88460	1578738282
Torno, Lilibeth	MD	Oncology	A50517	1235227943
Wang, Victor	MD	Oncology	A113969	1265776587
OPHTHALMOLOGY Phone (714) 289-2389 Fax (714) 289-2390			**LICENSE**	**NPI**
Bhola, Rahul	MD	Ophthalmology	C144757	1609910033
Manchandia, Ajay M	MD	Ophthalmology	A120510	1720243082
Weiss, Sidney	MD	Ophthalmology	G27151	1578584231
OTOLARYNGOLOGY Phone (714) 633-4020 Fax (714) 953-5462			**LICENSE**	**NPI**
Ahuja, Gurpreet	MD	Otolaryngology	A54475	1013970169

Bhatt, Jay	MD	Otolaryngology	A126898	1174880496
Chang, David T.	MD	Otolaryngology	A117677	1407172075
Huoh, Kevin	MD	Otolaryngology	A106715	1245471275
Pham, Nguyen	MD	Otolaryngology	A102823	1861661373
Zhong, Qiu	MD	Otolaryngology	A131645	1609185990
PEDIATRIC GENERAL & THORACIC SURGERY Phone (714) 364-4050 Fax (714) 364-4051			**LICENSE**	**NPI**
Awan, Saeed-Ur-Rehman	MD	Pediatric Surgery	C55769	1457691685
Gholizadeh, Maryam	MD	Pediatric Surgery	A83935	1194724583
Gibbs, David	MD	Pediatric Surgery	G79479	1467432609
Guner, Yigit S.	MD	Pediatric Surgery	A89069	1851375828
Kabeer, Mustafa	MD	Pediatric Surgery	G86862	1093795239
Reyna, Troy	MD	Pediatric Surgery	G87971	1659371581
Yu, Peter T.	MD	Pediatric Surgery	A100686	1215109004
PSYCHIATRY Phone (714) 509-8481 Fax (714) 509-8759 Appointments (888) 770-2462			**LICENSE**	**NPI**
Hwang, Michael S.	MD	Pediatric Psychiatry	A121559	1336382316
Lai, Laura	MD	Pediatric Psychiatry	A136143	1518300078
Nguyen, Hoang (Wanye)	MD	Pediatric Psychiatry	A69179	1841240769
Relia, Sachin	MD	Pediatric Psychiatry	A119785	1497989347
Suzuki, Alejanda	MD	Pediatric Psychiatry	A723229	1730213497
Yang, Esther	MD	Pediatric Psychiatry	A125272	1013208552
Wusirika, Lavanya	MD	Pediatric Psychiatry	A136831	1922441211
PULMONOLOGY Phone (714) 509-8622 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Chin, Chana	MD	Pulmonology	A112215	1033457270
Gage, Susan	MD	Pulmonology	A111459	1396060554
Hong, Hanna	MD	Pulmonology	A126707	1023364692
Kamath, Sunil	MD	Pulmonology	A100527	1194985002
Nakra, Neal K.	MD	Pulmonology- Sleep Medicine	C135395	1558561597
Tirakitsoontorn, Pornchai	MD	Pulmonology	A64929	1427085810
Yuengsrigul, Anchalee	MD	Pulmonology	A53260	1700972536
RADIOLOGY Phone (714) 509-9081 Fax (714) 509-9078 Appointments (888) 770-2462			**LICENSE**	**NPI**
Beydoun, Tammam	DO	Vascular & Interventional Radiology	20A14487	1033349014
Dao, Tuan*	MD	Pediatric & Diagnostic Radiology	A139553	1134354079
Eghbal, Azam*	MD	Pediatric & Diagnostic Radiology	C55958	1821097569
Lai, Hollie*	MD	Pediatric & Diagnostic Radiology	A62577	1124123609
Holmes, William (Nathan)*	MD	Pediatric & Diagnostic Radiology	A104831	1700811700
Bula, Melanie L* (ARIS)	MD	Pediatric & Diagnostic Radiology	A111302	1205152006
Chang, Johanna M* (ARIS)	MD	Pediatric & Diagnostic Radiology	A110028	1356570980
Craychee, Judith A* (ARIS)	MD	Pediatric & Diagnostic Radiology	G82280	1831198472
Galvez, Michelle A* (ARIS)	MD	Pediatric & Diagnostic Radiology	A122310	1043483175
Gyves-Ray, Katherine* (ARIS)	MD	Pediatric & Diagnostic Radiology	G88889	1578521811
Halabi, Safwan* (ARIS)	MD	Pediatric & Diagnostic Radiology	A105003	1669491320
Iqbal, Vassem* (ARIS)	MD	Pediatric & Diagnostic Radiology	G88289	1780655548
Katz, Michael* (ARIS)	MD	Pediatric & Diagnostic Radiology	G88982	1861463390
Machado, Sandra* (ARIS)	MD	Pediatric & Diagnostic Radiology	A109969	1265639710
Nahl, Daniel*	DO	Pediatric & Diagnostic Radiology	20A15315	1053672725
Sung, Andrew J.*	MD	Pediatric & Diagnostic Radiology	A138377	1265875561
RHEUMATOLOGY Phone (714) 509-8617 Fax (855) 246-2329 Appointments (888) 770-2462			**LICENSE**	**NPI**
Lim, Emilina	MD	Rheumatology	C141929	1235289273
Shulman, Andrew	MD	Rheumatology	A122794	1760649842

MISC. SERVICES			LICENSE	NPI
Irwin, Melanie C. Nicole **PH: (714) 835-2724**	MD	Physical Medicine & Rehabilitation	A99872	1518918358
Keating, Sarah L. **PH: (888) 770-2462**	MD	Hospice and Palliative Care Medicine	A141346	1831509421
Wong, Daphne **PH: (714) 509-8338**	MD	Child Abuse	A60029	1740291467
Triebwasser, Harvey S. **PH: (888) 770-2462**	MD	Adolescent Medicine	G20277	1144352840
Yonan, Terez **PH: (888) 770-2462**	MD	Adolescent Medicine	20A13412	1578853685
Roche, Alexandra **PH: (888) 770-2462**	MD	Adolescent Medicine	A94044	1164540126
Nassif, Nader **PH: (888) 770-2462**	MD	Orthopedic Surgery/Limb Salvage	A125009	1629262183
Olson, Douglas P. **PH: (888) 770-2462**	DMD	Orthodontics	DDS104517	1144369125

SUBJECT: Emergency and Urgently Needed Services **Policy #:** UM5
DEPARTMENT: Utilization Management

Effective Date: February 1, 1999
Last Revision Date: October 4th, 2024,
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure the IPA provides geographically accessible health service both during and after hours. Qualified personnel must be available to provide immediate, medically necessary services twenty-four (24) hours a day, seven (7) days a week.

POLICY:

All licensed and unlicensed staff should be oriented to emergency procedures within the office when hired and upon annual review.

At least one licensed staff person is required to be trained and certified in Cardiopulmonary Resuscitation (CPR and Basic Life Support (BLS). Advanced Life Support (ALS) certification is recommended, but not required for licensed MDs, RN, RNP and PAs.

Members are encouraged to appropriately use the "911" emergency response system when they have an emergency medical condition which requires an emergency response.

Telephone triage ensures that all members receive safe, appropriate, and timely care for emergent and urgently needed services. If the primary care physician utilizes the services of a telephone advice service, the entity utilized must be registered with the Department of Consumer Affairs and have qualified personnel.

If the member contacts their Primary Care Physician, qualified personnel will assess medical necessity. As a result, the member may be advised to go to the nearest emergency room, see their PCP the same or next working day or provided alternative resources.

Members needing Urgent Care services will be seen within 48 hours of request.

Members are not required to obtain an authorization from their Primary Care Provider for emergency medical services from in network or out of network providers. The Primary Care physician is responsible for educating the member on the use appropriate use of Primary Care and Emergency Services and follow-up processes available after-hours, such as urgent care, on-call nurse advice line or after-hours physician services.

Emergency and/or Urgent Care claims will not be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the

claimant, for example, the member is unconscious and in need of immediate care at the time medical treatment is required.

The UM Coordinators may receive calls requesting authorization from a contracted, a non-contracted or an out-of-area non-contracted facility. The Medical Director will immediately be contacted for directions of authorization, follow-up care and hospital transfer responsibilities. The facility requesting verbal authorization for post-stabilization care must receive a response from the IPA or Medical Group within 30 minutes of receipt of the request; otherwise, the facility may assume authorization has been given. All telephone triage, emergency room, ambulance transportation, alternative care and follow up information is documented according to the authorization of services policy.

The IPA will not require a hospital to make more than one telephone call to request authorization to provide post-stabilization care to members. The IPA will provide hospitals with one telephone number to serve as the point of contact for 24-hour post stabilization authorization requests and will not require the hospital to contact the IPA in any way other than the designated phone number.

A Medical Screening Exam may take place at the Emergency Department without prior authorization, to assess the condition or severity of illness. The triage will include any recommendations for hospital admission and/or post hospital care and follow up, discharge planning to follow up with primary care or specialty services.

If the Medical Screening Exam determines that the member's condition is not an emergency, the member is responsible to arrange follow up care with their Primary Care Physician. The ER Department should contact the member's primary care physician to arrange follow-up care in circumstances where there are ongoing care needs. The Primary Care Physician is then responsible for ensuring follow-up care is performed.

For CalOptima OneCare and Medicare, a request for authorization for post-stabilization following a screening exam must be responded to by the Primary Care Physician, IPA Medical Director and/or the UM staff within 60 minutes of the receipt of the request. If an authorization decision is not communicated to the requesting Emergency Department within 60 minutes, the Emergency Department may assume authorization has been given.

The Primary Care Physician is responsible for notifying the UM Department of all member visits to the Emergency Room, even if the screening exam results in non-emergent care. The UM Coordinator will log the Emergency Room visit and initiate an Emergency Room follow up letter to remind the member to follow up with their Primary Care Physician.

> All "911" calls and emergency triage will not be retrospectively denied or analyzed for diagnostic necessity, i.e. if the care meets the Emergency Medical Condition (See Definition) or if the care was authorized by an authorized IPA provider. An emergency screening fee (Medical Screening Exam) is paid for all ER Claims where clinical data supporting a higher level of pay is not available. All other Emergency Room services will require a physician review of presenting symptoms and discharge diagnosis prior to denying an ER Claim, including ER denials issued through an automated claims system.

In a case where the member is treated in the Emergency Room and stabilized, and the ER Physicians/treating provider feels the member may not be discharged safely, the IPA will adhere to the recommendations of the ER Physician/treating provider and automatically approve the first 24 hours.

Any proceeding days will be reviewed by the Medical Director and discussed with the treating provider.

If at any time the Medical Director and Treating Physician are in disagreement about the safety and necessity of treatment and/or transfer, the Medical Director will request that one of the contracting providers take over care for the member.

DEFINITION[i]:

Emergency Medical Condition: A condition manifesting itself by acute symptoms of sufficient severity (including severe pain) whereby a member with an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman and the health of her unborn child.
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services: Services required to treat a bodily injury or a serious medical or psychiatric illness that a member reasonably would believe may result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Services may be Inpatient and outpatient, furnished by a provider qualified to perform emergency services and needed service to evaluate or stabilize an emergency medical condition.

Urgently Needed Services: Services which are provided when a member is temporarily absent from the medical group's service area or under unusual and extraordinary circumstances, provided when the member is in the service area, but the member's provider network is temporarily unavailable or inaccessible.

Medical Screening Exam: An initial assessment of a member to determine whether the member should be treated in the emergency room department or may be safely treated at another level of care.

Post-Stabilization timing requirement: A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize post-stabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

PROCEDURE:

A. Emergency Assessment - For the primary care office setting, the Physicians (MD), Registered Nurse or Registered Nurse Practitioner (RN/RNP) or Physician Assistant (PA) on duty is responsible for

providing triage and emergency services to members in need. At a minimum, the process for assessment should be as follows:

1. Inquire about the presenting symptoms and perform a visual assessment of the patient.
2. Document and record the vital signs (pulse, respiration, temperature, blood pressure, and when appropriate, height and weight.
3. When assessed as emergent, notify the physician and "triage team". Place the patient in an exam room if possible. If necessary, start a normal saline IV, administer oxygen, or insert an oral airway.

B. Emergency Equipment/Supplies - Each primary care physician office will have emergency equipment, medications and supplies properly secured, available, current and up to date. The following Emergency equipment and supplies will be on hand:

1. Benadryl 50 mg/ml
2. Adrenaline 1:1000/cc
3. Nitrostat 1/150 gr. (0.4 mg)
4. Solu-Medrol 40 mg/1cc Mix-o-Vial
5. Airways – 3 sizes (small, medium, large)
6. Pediatric and adult Ambu bag
7. Oxygen tank with a flow meter, mask and/or cannula attached and ready for immediate use.

C. Telephone Triage – In accordance with standards of practice, only licensed personnel, i.e., physicians, registered nurses, nurse practitioners and physician assistants may perform telephonic assessment of a patient complaint or problem.

1. When a call is received from the Emergency Department staff or providers, the following information may be gathered and documented for the authorization determination process:

    a. Working Diagnosis
    b. Vital signs
    c. Chief complaints and symptoms (i.e., bleeding, chest pain, impaired neurological status, etc.)
    d. Method in which the member presented into Emergency Department (i.e., Ambulance, paramedics, police transport, employer, parent, spouse, friend, self-transport, etc.)
    e. Duration of the condition such as sudden onset or length of days or weeks.
    f. Treatment or services already provided (i.e., suturing, injections, medications, IV fluids, oxygen, etc.)
    g. Procedures or tests already conducted or planned (i.e., Chest tube insertion, X-rays, MRI, laboratory work, etc.)
    h. Actual or suggested type of discharge from the Emergency Department (i.e., hospital admission, transfer to another facility, discharge home with instruction and follow up-by PCP, etc.)
    i. Time of visit and if visit occurred during primary care physician's office hours, after-hours or on the weekend.
2. If verbal authorization is given for emergent or urgently needed services through telephone triage, it is binding and may not be overturned by the group's UM authorization process.

3. Emergency Department requests for authorization for post-stabilization and non-urgent care following a screening exam must be responded to by the Primary Care Physician, the IPA Medical Director and/or the UM Staff within 30 minutes of receipt of the request. If an authorization decision is not communicated to the requesting Emergency Department within 30 minutes, the Emergency Department may assume authorization has been given.

4. For CalOptima OneCare and Medicare, a request for authorization for post-stabilization following a screening exam must be responded to by the Primary Care Physician, IPA Medical Director and/or the UM staff within 60 minutes of the receipt of the request. If an authorization decision is not communicated to the requesting Emergency Department within 60 minutes, the Emergency Department may assume authorization has been given.

D. Service Denials – If the urgent or emergent service results in a denial, the IPA will notify members and providers immediately of the decision with instructions provided for how to initiate an expedited appeal. Written notification will follow within two days of denial determination.

E. Ambulance Transportation – The UM staff, Primary Care Physician and/or Medical Director will arrange ambulance transport to the nearest emergency facility by a licensed and contracted ambulance company or through "911" if no area contract exists.

F. Utilization Department Notification - The authorizing physician is responsible for notifying the UM Department of all Emergency services authorized within 24 hours of authorization of service or next business day.

G. Emergency Reporting/Tracking –The authorizing physician and the UM Department is responsible to monitor and document all in and out-of-area emergency room visits and hospitalizations. Minimal documentation includes the name of member, subscriber identification, treating facility, location, name of provider making the request, authoring physician's name, date and time of services, type of treatment, Diagnosis, Services performed, disposition, transportation and follow up care.

H. Retrospective Review of ER Service – At anytime a request is made for retro review of ER service(s) by the Primary Care Physician, Medical Director, Physician Reviewer or an UM Committee physician, the UM Coordinators will ensure that all necessary information such as the ER summary including presenting symptoms and discharge diagnosis will be available for determination to be made.

I. The UM Department will send a report of all Emergency service notifications to the health plans monthly, as required. Emergency Room treatment on shared and some dual risk contracts may require that the health plan receive notification directly from the treating facility. The medical group may need to authorize or provide a tracking number to the hospital to ensure reporting and claims payment.

J. An Emergency Room follow up letter will be sent after notification of any member's visit to the Emergency Room, even if the visit resulted in a Medical Screening Exam. A copy of the letter will be faxed to the Primary Care Physician for his staff to document follow-up requests and arrange follow up appointment.

K. Because no prior authorization is required to obtain emergency room treatment, there may be times when notification comes at the time of receipt of the claim. A report of all ER claims can be run and checked against encounter data to determine if the member has followed up with their Primary Care Physician. ER follow up care can be monitored and logged for presentation at UM Meetings for intervention.

FORMS:

Emergency Room Notification Worksheet
Referral Authorization Worksheet

REFERENCES:

Title 22 California Code of Regulations, Section 51301
Title 28 California Code of Regulations, Section 1300.67.2
Title 28 California Code of Regulations, Section 1300.71.4
California Health and Safety Code 1371.4 (a)-(d)
APL 23-009 Post Stabilization Care
CalOptima Health Policy & Procedure GG.1508.
APL 24-012 Single Point of Contact for Hospitals to Request Authorization for Post stabilization Care
42 CFR 422.113(c)(2)(ii) Special Rules for Ambulance Services, Emergency and urgently needed services, and maintenance and post-stabilization care services.
Cal. Code Regs. Tit. 22, § 51056

[i] 1999 Medicare CFP definition for Emergency Medical Condition, Emergency and Urgently Needed Services.

AUTHORIZATION PROCESS FOR LONG TERM CARE

SUBJECT: Care Coordination Standards & Long Term Support Services **Policy #:** CM8

DEPARTMENT: Case Management

Effective Date: April 1, 2014
Last Revision Date: February 2015
Last Review: January 2023

SCOPE:

This policy applies to the Duals Demonstration – Cal MediConnect

PURPOSE:

To define the process for training and implementation of the California Coordinated Care Initiative [CCI] Care Coordination Standards and Community Resource programs for Cal MediConnect members.

POLICY:

Case Management activities for Cal MediConnect members will adhere to all required California Coordinated Care Initiative [CCI] Care Coordination Standards. Training materials may be received from the health plan and/or from www.calduals.org.

Annually, all UM and CM Staff will be trained on eligibility for Multipurpose Senior Service Program [MSSP], Long Term Care [LTC], Community Based Adult Services [CBAS], In-Home Support Services [IHSS] and/or Home and Community-Based Services [HCBS], the Care Coordination Standards, MSSP and its role in supporting members and process for referring members to these programs.

The health plan's designated Case Manager will assess and referred the member to these services and participate in the coordination of care with the specific agency. The agency or designated program representative will be included in Care Planning process.

DEFINITIONS:

LONG TERM SUPPORT SERVICES [LTSS]: Plans work in partnership with consumers and advocates, providers and others to create a sustainable, person-driven long-term support system in which people with disabilities and chronic conditions have a choice, control and access to a full array of quality services that assures optimal outcomes, independence, health and quality of life. The goals of LTSS are to provide an alternate to institutional placement, seamless delivery, physical and programmatic accessibility, member centered care coordination and integration with medical and behavioral health. These services may include a Multipurpose Senior Service Program [MSSP], Long Term Care [LTC], Community Based Adult Services [CBAS], In-Home Support Services [IHSS] and/or Home and Community-Based Services [HCBS].

These services include but are not limited to: supplemental personal care services, supplemental chores, supplemental protective services, in home skilled Nursing care and therapies services for chronic conditions, Respite Care (in home or out of home), nutritional supplements and home delivered meals.

PROCEDURE:

1. Annual training of Long-Term Support Services will occur at a minimum annually or after any changes to current program. Training will include a description of the services, eligibility criteria, member's rights and or grievance and appeals process and the referral process. Each staff member shall attest to training and the manager will maintain a log of participation.
2. Referrals for these programs will be coordinated with the member's designated health plan representative for coordination of care.

FORMS:
None. All forms are within on-line system

REFERENCES:
Policy and Procedure CM 1 – Case Management Assessment

SUBJECT: Enhanced Care Management **Policy #:** CM11

DEPARTMENT: Case Management

Effective Date: January 1, 2022
Last Revision Date: October 8th, 2024,
Last Review: January 2026

SCOPE:

This policy applies to Medi-Cal plans that delegate Enhanced Care Management [ECM] under the California Advancing and Innovating Medi-Cal for All [Cal AIM].

- When not delegated, the Case Manager may be called upon for assistance with coordinating activity in conjunction with the member's Plan. This may involve Case Manager participation in the plan's Care Team Meetings or relaying information to the member's Health Plan or Primary Care Physician as requested.

Enhanced Care Management, where delegated, will be implemented in the following phases as approved by the Department of Health Care Services [DHCS]:

- Phase 1: No sooner than January 1, 2022, for members experiencing Homelessness, adults with high utilization and adults with Serious Mental Illness [SMI] or Substance Use Disorder [SUD].

- Phase 2: No sooner than January 1, 2023, for adult members in Long Term Care and who are at risk for institutionalization, adult nursing facility residents and adults transitioning from incarceration.

- Phase 3: No sooner than July 1, 2023, for Children and youth with eligible conditions.

Members enrolled in Health Homes Programs and Whole Person Care will also transition into ECM. No later than one month prior to January 1, 2022, or the ECM date approved by DHCS, identification of members will begin to ensure no disruption of services. Coordination of transition into the ECM program will occur until the member is reached or until at least 3 unsuccessful attempts occurred and are documented. A complete reassessment for HP and WPC transitioning members will occur within 6 months of the ECM program start date.

ECM Core Service Components include:
1. Outreach and Engagement
2. Comprehensive Assessment and care management plans
3. Enhanced Coordination of Care
4. Health Promotion, including but not limited to identification and building support network, coaching and encouragement of healthy lifestyle, skill strengthening to identify and access resources and link members with health management resources.
5. Comprehensive transitional care
6. Member and Family supports; and
7. Coordination of and referral to Health Plan Community Support Services and community-based social support services.

<u>Enhanced Care Management Eligibility/Population of Focus</u>:

ECM will be provided to all Medi-Cal only members who meet eligibility criteria, agree to participate, and are authorized for these services. Members with Original Medicare or a Medicare Advantage Plan with Medi-Cal secondary coverage or a Dual-Eligible Special Needs Plan may participate if they are referred, meet criteria for one or more of the populations of focus and agree to participate.

To be eligible for the ECM, members must meet the following Population of Focus criteria according to the phase implementation above:

1. Individuals (Adults), Families, and Unaccompanied children/youth experiencing Homelessness, with:
    a. Individual or family who lacks adequate nighttime residence;
    b. Individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation such as, a car, park, abandoned building, bus or train station, airport, or camping ground.
    c. Individual or family living in a shelter.
    d. Individual exiting an institution into homelessness.
    e. Individual or family who will imminently lose housing in next **30 days**.
    f. Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes; or
    g. Individuals fleeing domestic violence, trafficking, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;
    h. Family or Unaccompanied Children/youth sharing the housing of other persons (i.e., couch surfing) due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or abandoned in hospitals.
    i. At least one complex physical, behavioral, or developmental health need; and
    j. Are unable to successfully manage their health; and
    k. Coordination of services will likely improve health outcomes or decrease the amount of high-cost services utilized by the member.

2. Adult high utilizers, including members experiencing one or more of the following within a 6-month period and which could be avoided with appropriate level of care and/or improved treatment adherence:
    a. Five or more Emergency room visits; or
    b. Three or more unplanned hospital admissions; or
    c. Three or more short term, skilled nursing facility stays.
    d. For this Population of Focus (POF), the IPA may choose to authorize ECM for individuals who are at risk for avoidable hospital or emergency department utilization and who would benefit from ECM but who may not meet the numerical thresholds specified above.

3. Adults with Serious Mental Illness [SMI] or Substance Use Disorder [SUD] who meet one or more of the following criteria:
    a. Are actively experiencing at least one (1) complex social factor influencing their health including but not limited to (lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms); and
    b. High Risk for institutionalization, overdose and/or suicide; or
    c. Utilizing crisis services, emergency rooms, urgent care, or inpatient hospital stays as their primary source of behavioral or physical care; or
    d. Two or more emergency Department visit or hospitalization within the past twelve months because of SMI or SUD; or

e. Pregnant or post-partum women (twelve (12) months from delivery).; or
f. For members where the County Mental Health provider has identified that the member can benefit from intensive care management or nontraditional supports and is currently providing supportive services that are not Medi-Cal reimbursable under SMH or Drug Medi-Cal/Drug Medi-Cal Organized Delivery System [DMC/DMC-ODS] benefits but could be covered through ECM.

4. Adults eligible for Long Term Care [LTC] and who are at risk for institutionalization; and
    a. Are living in the community and meet the SNF Level of Care (LOC); or who require lower acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illnesses or injury; and
    b. Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring); and
    c. Without services and supports who would require care for ninety consecutive days or more in an inpatient nursing facility; and
    d. Must be able to live safely with wraparound supports.

5. Adult nursing facility residents who:
    a. Want to transition back into the community; and
    b. Are strong candidates for a successful transition.
    c. Are able to reside safely in the community.

6. Adults transitioning from incarceration. Adults who are transitioning from incarceration or transitioned from incarceration within the past twelve (12) months, and who have at least one of the following conditions:
    a. Mental illness;
    b. SUD;
    c. Chronic Conditions/significant Non-Chronic Clinical Condition;
    d. Intellectual or Developmental Disability (I/DD);
    e. Traumatic brain injury (TBI);
    f. HIV/AIDS; or
    g. Pregnancy or Postpartum.

7. All other children and youth who have/are:
    a. Children (up to Age 21) Experiencing Homelessness;
    b. High utilizers; or
        i. Have three (3) or more emergency department visits in a twelve (12)-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; or
        ii. Two (2) or more unplanned hospital and/or short-term SNF stays in a twelve (12)-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;
    c. Serious Emotional Disturbance [SED] or identified to be at a clinical high risk for experiencing a first episode of psychosis; or
    d. Enrolled in California Children's Services (CCS)/CCS Whole Child Model with additional needs beyond the CCS eligible condition;

e. Involved in, or with a history of involvement in child welfare services [including foster care up to age 26]; or
f. Transitioning from incarceration.

8. Birth Equity POF (Adults and Youth)
    a. Pregnant or postpartum (through twelve (12) months period); and
    b. Meet one (1) or more of the following conditions:
    (a) Qualify for eligibility in any other adult or youth ECM POF; and/or
    (b) Birth Equity POF effective January 1, 2024, are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

ECM Member Eligibility exclusions:
Medi-Cal beneficiaries enrolled in other programs are excluded from ECM.

1. Members enrolled in a Program for All Inclusive care for the Elderly [PACE].

2. Members enrolled in 1915(c) Waiver Programs can enroll in ECM or the waiver program but not both at the same time as Multipurpose Senior Service Program [MSSP], Assisted Living Waiver [ALW], Home and Community Based Alternatives [HCBA], HIV/AIDS Waiver; HCBS Waiver for Individuals with Developmental Disabilities [DD] or Self-Determination Program for Individuals with I/DD. In addition, members enrolled in California Community Transitions [CCT] Money Follows the Person [MFTP] Program may be enrolled but not at the same time as this program.

3. As services are not duplicated, members enrolled in County-based Targeted Case Management [TCM], Specialty Mental Health [SMHS] TCM, SMHS Intensive Care Coordination for Children [ICC], DMC-ODS, California Children's Services [CCS] or Whole Child Model and Community Based Services [CBAS], may participate in ECM.

4. Basic or complex case management programs;

5. Hospice;

6. California Community Transitions (CCT) Money Follows the Person (MFTP); and

7. Family Mosaic Project Services.

Members will be identified for possible enrollment into ECM services by the following avenues:
1. Provider Referrals
2. Member or a Family Member, Guardian, Caregiver, and/or Member's Authorized Representative support person
3. Community-based entities, including those contracted to provide In Lieu of Services [ILOS]
4. Other Providers who service potential ECM members.
5. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) who were receiving ECM
    a. Health Plan will inform IPA if the transitioning member is previously receiving ECM during the last 90 days of enrollment in the previous MCP and did not subsequently either meet graduation criteria or choose to discontinue ECM;
    b. Health Plan will inform IPA if member previously received ECM during the last 90 days of enrollment and recommends continuation of ECM; or
    c. Health Plan or IPA becomes aware that a newly enrolled Member received ECM during the last 90 days of enrollment in the previous MCP, in any other way.

Members may be identified for proactive outreach and engagement who may meet eligibility requirements from review of historical data, including but not limited to:

1. Enrollment Data
2. Outreach List from Health Plans
3. Claims Encounter Data
4. Utilization/Authorization Data
5. Pharmacy Data
6. Laboratory Data
7. Information from Member assessments, including:
    c. Staying Healthy Assessment [SHA]/Individual Health Education Behavioral Assessment [IHEBA];
    d. Seniors and Persons with Disabilities Health Risk Assessment.
    e. Health Information Form [HIF]/Member Evaluation tool; and or
    f. Any superseding assessment released by DHCS.
8. Clinical information on physical/behavioral health
9. SMU/SUD data, as available
10. Long Term Support Services needs
11. CCS Whole Child Model stratification information.
12. Information about Social Determinants of Health and/or Adverse Childhood Experiences
13. Other available cross-sector data and information, including housing, social services, foster care, criminal justice history and other information relating to focus of ECM.

Referrals may be received via fax or verbally or CalOptima Connect portal for ECM related services and will be processed by the Case Management (CM) department. If the referral is received from the CalOptima Connect portal, CM will document the referral information and or updates in the portal.

Determinations are made with consideration to the member's need for intense, comprehensive care coordination and their ability to benefit from ECM and the Member's agreement to receive such services.

Members receiving ECM may request to change their ECM Provider at any time. Changes will be implemented within 30 days.

All members are entitled to appeals and grievance processes in accordance with their assigned health plan's process.

ECM Outreach and Engagement:
Outreach will occur until the member is reached or at least 3 attempts have been completed.

Members can decline or discontinue ECM upon initial outreach and engagement, or at another time.

ECM Providers shall outreach to members meeting criteria for a defined Population of Focus as follows:

1. Member engagement shall be primarily performed through in-person contact, according to the member preference and the needs of each Population of Focus.

2. If in-person engagement is not available or appropriate, and ECM Provider shall engage an ECM member via telephone, mail, or other written communication.

i. Outreach activities to members in the Homeless Population of Focus may include but is not limited to:
    i. In person, telephonic or video visits at local homeless shelters, navigation centers and hot spots where homeless members may spend time.
    ii. In person, by telephone or video visits to Recuperative Care facilities.
    iii. Coordination between Homeless Response Team and Clinical Field Teams acting as ECM ambassadors; and
    iv. Collaboration with community clinics, providers and other community-based organizations who care for members experiencing homelessness.

j. Outreach to members in the High Utilizer Population of Focus may include but is not limited to:
    i. In person, telephonic or video communication, as appropriate, during a hospital or nursing home stay, or as part of discharge planning process.
    ii. In person, telephonic or video communication, as appropriate, following an emergency room visit.
    iii. Collaboration with contracted hospital staff serving members with high utilization of Emergency Room and inpatient hospital services; and
    iv. Education in the usual course of communication with member

k. Outreach to members in the SMI/SUD Population of Focus may include but is not limited to:
    i. In person, telephonic or video communication, as appropriate, during a hospital stay or as part of discharge planning or following an emergency room visit.; and
    ii. Collaboration with County Mental Health staff, Drug Medi-Cal Providers, and hospital providers.

3. A Member may accept or decline ECM services. The ECM Provider shall honor the Member's decision and document in the system of record.

ECM Provider Requirements:
Providers will be educated on the ECM services, eligibility requirements and how to request these services annually. Trainings will include education on the ECM program overview including but not limited to care plan, care coordination and care transition requirements, service referrals, community resources, and Cal AIM Populations of Focus, Social Determinants of Health, trauma informed care, health literacy, culturally competent communication, data, and reporting requirements.

ECM Providers will:
1. Ensure all ECM members receive all ECM Core Service Components
2. Operate in the area where the member resides.
3. Serve the members with respect for their choice and cultural diversity by recruiting staff that reflect the culture they serve and provide care management services with cultural and linguistic competency and humility.
4. Have experience and expertise with the population served.
5. Comply with applicable state and federal laws and regulatory requirements.
6. Maintain capacity to provide culturally appropriate and timely in person care management activities, including accompanying members to critical appointments, where necessary.
7. Able to communicate in culturally and linguistically appropriate and assessable ways.

8. Have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, specialists, and other entities, to coordinate care for members as appropriate.
9. Utilize a care management documentation system that supports integration of physical, behavioral, social services, and administrative data and information to support the management and maintenance of care plans.
10. Maintain a process for sharing Member care plans with other providers and organizations involved in each member's care, as appropriate.
11. Honor member choice in assigning members to ECM Providers.
12. Maintain all continuity of care for member's transitioning in and out of ECM.
13. Utilize plan approved written materials in consideration of members linguistic needs.
14. Inform members, family members, guardians, caregivers, and Authorized Representatives about ECM services.
15. Utilize an integrative system to maintain records of claims/encounter data and will submit data and other supplemental reports to plans timely as required.
16. Coordinate with the health plan's oversight monitoring processes.

PROCEDURE:

1. Upon identification of a member who may benefit from ECM, a Lead Case Manager with expertise and skills to meet the member will be assigned to the case.

2. The LCM will assess eligibility and participation in ECM. If found to be eligible, the Member will be contacted to identify their preference for participation. Upon agreement for participation and case is opened in the system.

3. The LCM will evaluate each core service component:

   A. Outreach and Engagement:
      1) When delegated for ECM, the group will collaborate with the plan on targeted outreach and engagement for members identified from the plan's Member Transition List [MTL].

      2) Upon referral or identification of a member who may benefit from ECM, the member will be assigned a Lead Case Manager [LCM], with expertise and skills to meet member needs, who is responsible for interacting directly with the member and/or family, Authorized Representative, caretakers, and other authorized support persons as appropriate. Members' urgent needs will be assessed and identified at the time of referral. Outreach may be prioritized to those with the most immediate needs.

      3) The LCM will open a case in the system to document outreach activities.
      4) A minimum of three (3) progressive attempts to engage the member within the 1st 90 days of the program onset. Progressive engagement may include but is not limited to mailed and other written communication, live calls and in person engagement.

      5) Where necessary, outreach activity may include processes to validate and update contact information which may require collaboration with community partners or providers for which there is documentation of prior services.

6) When all efforts have been exhausted and outreach is unsuccessful, an unable to contact notice will be mailed and the case will be closed in the system.

B. Comprehensive Assessment and Care Plan:

1). The Lead Case Manager is responsible for engaging with an interdisciplinary care team to:

a. Coordinate performance of a comprehensive assessment focused on identifying medical, psychosocial, and dental needs as well as Social Determinants of Health in the development of a member-centric care plan.
b. Identify gaps in care.
c. Coordinate all primary, medical, behavioral, developmental, and oral health needs, Long Term Support Services [LTSS], In-Lieu of Services [ILOS] and other services that address Social Determinants of Health.
d. Develop a person-centric care plan built around member goals, needs and choices, including:
    g. Member-centric goals
    ii. Measurable outcomes; and
    iii. Interventions to achieve Member goals.
e. The comprehensive, individualized, person-centric care plan will include input from the member and/or family member[s], guardian, or Authorized Representative, caregiver.
f. The care plan will include the Member strengths, risks, needs, goals, and preferences in addition to service needs.
g. The care plan will incorporate identified needs, strategies to address the needs, including but not limited to, physical and developmental health, mental health, dementia, substance use disorder, LTSS, oral health, palliative care needs, necessary community based and social service needs and housing.
h. A reassessment of the member's progress towards their goal will occur on a regular basis at a frequency appropriate for their progress. As the Member's needs change and goals are achieved or altered, the care plan shall be modified.
i. A copy of the care plan and any updates will be sent to members and appropriate support persons and will provide information on requesting updates.
j. Appropriate licensed clinical oversight will review and monitor the care plan.

2) ECM services shall be provided primarily through in-person contact and in a culturally competent manner.

3) When in-person communication is not available or does not meet the ECM Member's needs, alternative methods, such as Telehealth, video call assessments or telephonic communication will occur as per Member choice and availability and be culturally appropriate.

4) Eligibility for ECM will be re-evaluated every six months, and re-authorize ECM, if appropriate

5) ECM will be discontinued when case closure criteria are met.

C. Enhanced Coordination of Care:

1) ECM Members and their support persons will be contacted regularly to organize care plan activities as indicated in the care plan and shared with the member's multidisciplinary care team.

2) The multidisciplinary care team will include but is not limited to the ECM member, authorized support person, LCM, primary care provider, specialty care providers, ILOS providers and other disciplines and individuals per the member's needs and choice.

3) The LCM will maintain regular contact with the members of the multi-disciplinary care team and ensure care is continuous and integrated among all service providers. This included but is not limited to, communicating member's needs and preferences to the multidisciplinary care team timely.

4) The LCM will follow up with Primary Care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, necessary community based and social services including housing, as needed.

5) The LCM will engage the member in their treatment, including coordination for medication review and/or medication reconciliation, scheduling of appointments, as appropriate, while identifying and developing care plans for addressing barriers to care and member engagement in treatment. This may also include working with the member to identify and engage support persons and networks, coaching and encouraging health lifestyle behavior choices with the goal of creating self-sufficiency and the ability to successfully monitor and manage their health and assist the member in strengthening skills that enable the member to identify and access resources to assist them in managing existing and preventing emergence of additional chronic conditions.

D. Comprehensive Transitional Care Services:

1) Strategies will be developed to reduce avoidable admissions and readmissions, including, as appropriate:
    a. Through development and updating a transition plan
    b. Evaluation of medical needs and support services needed to facilitate safe and appropriate transitions across settings.
    c. Tracking of transitions across settings, including hospital facility, SNFs, residential or treatment facilities, incarceration facilities, or other treatment centers
    d. Coordination of medication review and/or reconciliation
    e. Provision of adherence support; and
    f. Leveraging technology, tools, services, as available, to provide real-time alerts that notify the LCM and care team about transitions.
2) TCS shall be provided for High-Risk Members, along with Members enrolled in Case Management or ECM through a single point of contact responsible for providing Longitudinal Support and ensuring all required services are complete which may be the TCS Assigned Care Manager; the ECM Lead Care Manager (LCM) for members enrolled in ECM; or the CCM Care Manager for members enrolled in Case Management.
3) At a minimum, the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager must act as a liaison coordinating care among the discharging facility, the Primary Care Practitioner (PCP), and Health plan.
4) TCS shall be provided for non-High-Risk Members.
5) TCS shall be provided to Members in Intermediate Care Facility/Developmentally Disabled (ICF/DD) Homes.
6) If a Member has an existing CCM Care Manager or ECM LCM the Health Network is responsible for notifying the CCM Care Manager or ECM LCM of the Admission, Discharge, and Transfer (ADT).

7) The Health Network and the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager is responsible for coordinating and verifying that Members receive all appropriate TCS, regardless of setting.
8) Health Networks shall ensure Prior Authorizations required for a Member's discharge are processed in a timely manner: Authorization and Processing of Referrals and Health Networks and the TCS Assigned Care Managers, ECM LCM, or CCM Care Manager shall collaborate with the facility on the discharge risk assessment and planning document for High-Risk Members.
9) The TCS Assigned Care Manager, ECM LCM or CCM Care Manager shall ensure needed post-discharge services are provided and referrals are made, follow-ups are scheduled and completed, including, but not limited to:
    a. Assisting with making follow up Provider appointments, to occur within seven (7) days post-discharge;
    b. Connecting to the PCP (if PCP has changed); and
    c. Arranging transportation, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.
    d. Substance Use Disorder, (SUD) and mental health treatment initiation or continuation for those who have an identified SUD or Mental health condition;
    e. Medication reconciliation, post discharge;
    f. Completion of referrals to social service organizations, and referrals to necessary at-home services (DME, home health, etc.);
    g. Connection to Community Supports as needed; and
    h. Members transitioning to or from nursing facilities.
10) If a second transition is within seven (7) calendar days of the first transition, then the TCS Assigned Care Manager, ECM LCM, or CCM Care Manager must ensure the follow up visit is completed within seven (7) calendar days post discharge after the last transition and continue to provide support for at least thirty (30) calendar days.
11) The Health Network shall ensure lower-risk Members have access to the following for at least thirty (30) calendar days from discharge:
    a. Have access to a dedicated TCS team;
    b. Have access to a dedicated telephonic support services with a live team; and
    c. Post-discharge Ambulatory follow up:
    d. Encourage that Member completes follow up ambulatory visit with Provider within thirty (30) calendar days of discharge.

=

E. <u>Member and Family Support</u>:

1) The LCM's coordination for Member and Family support will include but is not limited to:
    a. Assessment and documentation of ECM Member's family member[s], guardian, Authorized Representative, caregiver and/or Authorized Support Person[s] and promote effective communication.
    b. Coordination and education to the Member's chosen support person with the goal of improving the member's care planning, follow up and adherence to medication and treatment regimens.
    c. Servicing as the primary point of contact for the member and the member's support person
    d. Assess and identify the need for caregiver and support person resources and assistance with access; and
    e. Provide appropriate education for the ECM member and support person regarding member care instructions and needs.

F. Coordination of and referral to Community and Social Support Services:

1) Heath Plan Community Supports and other community based social support services requests may come from PCP/Providers, ECM Providers, the member, family member, guardian, caregiver, authorized support person and/or other community-based entity.

2) In addition, the LCM will coordinate with ECM providers to proactively identify members who may benefit from Health Plan Community Supports and other community-based support services including assessment of member eligibility for such services.

3) The LCM will coordinate with the ECM member and their support person[s]including:
   a. Assessment to determine community and social service needs and services available to the member, including those that address social determinants of health, such as housing support and other ILOS, as appropriate, including acceptance of service.
   b. Coordination of referrals, including follow-up to ensure services were rendered and confirmation that the member is engaged with community service providers, as appropriate.

4. ECM Member participation is voluntary:

A. Decline or discontinue Enhanced Care Management upon initial outreach or any time.
   1) When a member declines participation it will be documented in the system and the case will be closed.
   2) Notification is considered complete when the Member declines.

B. For members transitioning from HHP or WPC, the LCM will:
   1) Maintain the current established contact schedule.
   2) At the next contact schedule or within 6 months of the transition date, the LCM will perform a re-assessment of the Member to confirm appropriateness for ECM and need for ILOS.
      a. If during the re-assessment it is determined the member would benefit from a less intensive level of care management, the LCM will come to an agreement with the member prior to transitioning.

5. Participation in ECM will be evaluated every six months from the date the case is first referred, and services will be re-authorized as appropriate. The re-evaluation will be documented in the system.

6. If an ECM member requests a new LCM, consideration will be given to the clinical needs of the member, their language preferences, social and therapeutic considerations, and staff availability:

A. If re-assignment is appropriate and staff are available, the change shall be made within 30 days.
B. If re-assignment is not available, the case will be forwarded to the CM Department manager who will intervene to address the Member's concerns.

7. ECM cases may be closed:

A. The Member has met all care goals.

B. The Member is ready to transition to a lower level of care management where needs can be met from a telephonic model of care management and/or has fewer social determinants of health-related needs.

i. For Members who have engaged ECM services, and the member has been identified as no longer requiring the ECM level of services, the LCM will:
ii. Ensure the member agrees that the care goals are met and is ready to transition to a lower level of care management.
iii. Ensure the member agrees to the appropriate level of care support.
iv. Ensure coordination and documentation of transition to the appropriate level of care support.

C. The LCM has exhausted all efforts to reach the member after at least three attempts.

D. The Member is unresponsive or unwilling to participate or no longer wishes to participate in ECM.

E. The Member's behavior poses a risk to the care team and precludes the Member from participation in ECM.

SUBJECT: Community Supports [formerly In Lieu of Services-ILOS] **Policy #:** CM12

DEPARTMENT: Case Management

Effective Date: January 1, 2022
Last Revision Date: October 6, 2022
Last Review: January 2026

SCOPE:

This policy describes the eligibility criteria for Community Supports [CS] to Medi-Cal members under the California Advancing and Innovating Medi-Cal for All [Cal AIM] initiative.

- When not delegated, the Case Manager may be called upon for assistance with coordinating activity in conjunction with the member's Health Plan. This may involve Case Manager participation in the plan's Care Team Meetings or relaying information to the member's Health Plan or Primary Care Physician as requested.

POLICY:

Community Supports [formerly In Lieu of Services-ILOS], where delegated, will be implemented no sooner than January 2022 and may include but is not limited to the following services approved by the Department of Health Care Services [DHCS]:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services; and
- Recuperative Care/Medical Respite
- Additional services, as approved by DHCS for each specific health plan.

Health plans obtain approval every 6 months for their listed CS services. Plans may discontinue some CS on an annual basis with notice to DHCS. Should a service be discontinued, members will be transitioned seamlessly into other services or programs meeting their needs prior to discontinuance.

Community Support Providers [CSP] shall be credentialed and contracted with the IPA prior to utilization of service to ensure CSP or organization meets qualifications required. The following is a list of CSP qualifications required:

1. Housing Transition Navigation Services:
   a. Understanding of federal, state, and local transitional and permanent supporting housing programs and their requirements.
   b. Strong relationship with local housing authorities; and
   c. Local experience in the provision in Housing Transition Navigation Services

2. Housing Deposits:
   a. Understanding of federal, state, and local transitional and permanent supporting housing programs and their requirements.
   b. Strong relationship with local housing authorities; and
   c. Demonstrated or verifiable experience in providing these unique services.

3. Housing Tenancy and Sustaining Services:
   a. Understanding of federal, state, and local transitional and permanent supporting housing programs and their requirements.
   b. Demonstrated or verifiable experience in providing these unique services and supports.

4. Recuperative Care/Medical Respite:
   a. Demonstrated or verifiable experience and expertise in providing care in compliance with the National Standards for Recuperative Care; and

Community Support Services Training will occur annually, and training participation will be documented and maintained. The annual training will encompass the CS Program overview, the CSP's role, community resources for special populations, Social Determinants of Health, trauma-informed care, health literacy, data sharing and the health plan reporting requirements.

CS services must be prior authorized. Referrals for CS services may come from the Member and/or family members or Authorized Representative, Providers, or other community-based entities verbally or via fax.

When delegated, the prior authorization will be reviewed through the IPA's referral authorization process [See UM4 Referral Authorization Process] meeting all timeliness and notification requirements. As in all authorizations, the referral is tracked in the system and notification of outcome. The CS services referral is also flagged and reported to the member's assigned Case Manager. When not delegated, the assigned Case Manager will coordinate with the Health Plan's Case Management Department utilizing the health plan's required referral process and document in the system.

For participation in CS services, the member must be eligible within a Cal AIM Population of Focus [see P&P CM11 Enhanced Care Management] and meet the following DHCS-specific requirements, as follows:

I. <u>Housing Transition Navigation Services</u>

A. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

B. Members who meet the Housing and Urban Development (HUD) definition of homelessness (as defined in 24 CFR § 91.5) and meet one of the following criteria:

   1. Are receiving enhanced care management; and/or

   2. Have one or more serious chronic conditions; and/or

   3. Have a serious mental illness; and/or

   4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

C. Members who are determined to be at risk of experiencing homelessness if they have significant barriers to housing stability and meet one of the following:

   1. Have one or more serious chronic conditions.

   2. Have a serious mental illness.

3. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder.

4. Have a Serious Emotional Disturbance (children and adolescents).

5. Are receiving enhanced care management; or

6. Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

D. Member may not be receiving duplicate support from other State, local tax, or federally funded programs, which should always be considered first.

II. Housing Deposits

A. Any Member who received Housing Transition/Navigation Services Community Supports; and

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of Homeless; or

D. Members who meet the definition of an individual experiencing chronic Homelessness, either in Welfare & Institutions Code or as defined by HUD; or

E. Members who are determined to be at risk of experiencing homelessness if they have significant barriers to housing stability and meet one of the following:

1. Have one or more serious chronic conditions.

2. Have a serious mental illness.

3. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder.

4. Have a Serious Emotional Disturbance (children and adolescents);

5. Are receiving enhanced care management; or

6. Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking.

F. Individuals may not be receiving duplicate support from other State, local tax or federally funded programs, which should always be considered first.

III. Housing Tenancy and Sustaining Services

A. Any individual who received Housing Transition/Navigation Services Community Supports; and

B. Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Individuals who meet the Housing and Urban Development (HUD) definition of Homeless; or

D. Individuals who meet the definition of an individual experiencing chronic Homelessness, either in W&I Code or as defined by HUD; or

E. Individuals who are determined to be at risk of experiencing homelessness if they have significant barriers to housing stability and meet one of the following:

1. Have one or more serious chronic conditions.

2. Have a serious mental illness.

3. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder.

4. Have a Serious Emotional Disturbance (children and adolescents).

5. Are receiving enhanced care management; or

6. Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking.

F. Individuals may not be receiving duplicate support from other State, local tax or federally funded programs, which should always be considered first.

IV. <u>Recuperative Care</u>

A. Individuals who are at risk of hospitalization or are post-hospitalization, and

1. Live alone with no formal supports; or

2. Face housing insecurity, or

3. Have housing that would jeopardize their health and safety without modification.

B. Recuperative Care must be necessary to achieve or maintain medical stability and prevent hospital admission or readmission.

CS Services will be provided to ECM Members in accordance with the following requirements:

1. Housing Transition Navigation Services will be provided at an appropriate frequency for the needs of the member where specific barriers exist and will continue until:
   a. The Member is successfully placed in permanent housing and transitions to Housing Tenancy and Sustaining Services, as appropriate.
   b. The Member refuses services; or
   c. The Member loses funding and/or a housing voucher, where no resolution of the loss exists; or
   d. The Member is no longer physically, cognitively, or emotionally able to reside in independent supported housing; or
   e. The Member is no longer eligible for their Medi-Cal plan.

2. A member authorized for Housing Deposits will become ineligible if:

a. The Member refuses Housing Transition Navigation Services.
b. The Member is no longer physically, cognitively, or emotionally able to reside in independent supported housing; or
c. The Member is no longer eligible for their Medi-Cal plan.

3. Housing Tenancy and Sustaining Services will continue until:
   a. The Member's housing support determines they are no longer needed.
   b. The Member refuses Housing Tenancy and Sustaining Services.
   c. The Member loses funding and/or a housing voucher, where no resolution of the loss exists; or
   d. The Member is no longer eligible for their Medi-Cal plan.

4. Recuperative Care/Medical Respite will continue for 90 days or until:
   a. Services are no longer required for the Member and a discharge plan has been established.
   b. The Member refuses Recuperative Care.
   c. The Member is no longer eligible for their Medi-Cal plan.

The contracted CSP is responsible to:

1. Accept and act upon the referral for the authorized CS Services.
2. Conduct outreach to the Member within 24 hours of assignment or as soon as possible.
   a. This assessment may include identification of additional CS programs that may benefit the member and ensure referral to such program.
3. Maintain a staffed phone line or able to record voice mail, 24 hours a day/7 day a week and be responsive to incoming calls or other outreach from Members.
4. Coordinate with the providers in the Member's care team, including the Case Manager, other ILOS Providers and the Health Plan, as indicated.
5. Comply with cultural competency and linguistic requirements.
6. Shall not discriminate based on characteristics and must comply with applicable federal and state Civil Rights laws.
7. When the law requires authorization for data sharing, CSP shall obtain and document such authorization from each assigned member.
8. Support transition planning into other programs or services that meet the member's needs for any discontinuance of service for any reason.

For all CS Services, when a member loses eligibility with the IPA, the Case Manager will coordinate with the member's Health Plan to ensure continuity of care is considered.

CSPs and Members are entitled to grievances procedures.

PROCEDURE:

1. Members may be identified for proactive outreach and engagement who may meet eligibility requirements from review of historical data, including but not limited to:

   a) Enrollment Data
   b) Outreach List from Health Plans
   c) Claims Encounter Data
   d) Utilization/Authorization Data
   e) Pharmacy Data
   f) Laboratory Data

g) Information from Member assessments, including:
    i. Staying Healthy Assessment [SHA]/Individual Health Education Behavioral Assessment [IHEBA].
    ii. Seniors and Persons with Disabilities Health Risk Assessment.
    iii. Health Information Form [HIF]/Member Evaluation tool; and or
    iv. Any superseding assessment released by DHCS.
h) Clinical information on physical/behavioral health
i) SMU/SUD data, as available
j) Long Term Support Services needs
k) Well Child Model stratification information.
l) Information about Social Determinants of Health and/or Adverse Childhood Experiences

2. All requests for CS services will be tracked in the system.

3. Once the prior authorization is obtained, the coordination by the Case Manager with the CSP will occur within 2 business days, providing the demographics and appropriate clinical and social services information as appropriate to begin services.

4. If a Community Support Provider capacity is limited, prioritization of the initiation will occur for members who meet all criteria and demonstrate a high-level of commitment to participate in services.

5. The Case Manager will log the approved CS Service and CSP in the member's care plan notes.

6. The Case Manager will obtain regular updates from Community Support Provider regarding member's progress and participation with services. Updates can be obtained by written or verbal communications and for CalOptima members, by accessing CalOptima Connect, a share data source for information sharing.

7. The CSP will also be given administrative information needed to effectively provide the service, including but not limited to the billing information needed to submit claims and/or invoices.

8. The IPA will submit required reporting to the health plan as per their reporting requirements.

SUBJECT: Diabetes Self-Management **Policy #:** CM9

DEPARTMENT: Case Management

Effective Date: September 26,
Last Revision Date:
Last Review: 2014 January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure education on disease self-management and appropriate optimal treatment for diabetic members. Outpatient self- management training, education and medical nutrition therapy is provided to ensure proper use of diabetes equipment, supplies and medications.

POLICY:

Diabetic members and their family will have access to education on the diabetic disease process and the daily management of diabetic therapy. Self-Management training includes but is not limited to diet, education, self-monitoring of glucose levels, insulin administration and exercise.

Education may occur in the form of one-on-one education, class participation or distribution of handout materials, visual aids, video programs, etc.

Members may be referred to community-based education programs and/or referred to health plan disease management programs.

Education and reinforced monitoring of member compliance with self-management may also occur through one-on-one education by the member's primary care physician, Nurse Case Manager and/or Diabetes Educator and/or through referrals to specialists including but not limited to, Endocrinologists, Podiatrist, Ophthalmologist, Nephrologist, Diabetes Educator, or any additional self-management training needs as identified.

Members requiring complex monitoring of their compliance with self-management may be referred to the health plan's Case Management program, when not delegated to the group.

DEFINITIONS:

Diabetes**:** a metabolic disease in which the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood.

Diabetes Mellitus: a disorder of carbohydrate metabolism, usually occurring in genetically predisposed individuals, characterized by inadequate production or utilization of insulin, and resulting in excessive amounts of glucose in the blood and urine, excessive thirst, weight loss, and in some cases progressive destruction of small blood vessels leading to such complications as infections and gangrene of the limbs or blindness.

Type 1 Diabetes: Juvenile diabetes**.** a severe form of diabetes mellitus in which insulin production by the beta cells of the pancreas is impaired, usually resulting in dependence on externally administered insulin, the onset of the disease typically occurring before the age of 25.

Type 2 Diabetes: Adult-onset diabetes, a mild, sometimes asymptomatic form of diabetes mellitus characterized by diminished tissue sensitivity to insulin and sometimes by impaired beta cell function, exacerbated by obesity and often treatable by diet and exercise.

Diabetes Insipidus**:** Increased urine production caused by inadequate secretion of vasopressin by the pituitary gland.

PROCEDURE:

1. The Primary Care Physicians will offer on-going education to members with diabetes including but not limited to one-on-one education and/or class referrals and maintain documentation of education and referrals in the member's file.

2. Referrals to education classes for diabetes self-management or to specialty providers may be processed utilizing the UM referral form or health plan referral forms to health plan sponsored disease management programs.

3. Case Management will coordinate with members to identify needs for on-going monitoring and compliance with diabetes self-management.

4. Case Managers will work collaboratively with the member's PCP, specialist and/or Diabetic educator.

5. The Case Manager may refer members to classes and, where identified, to more complex case management.

FORMS:
UM referral form.
Health plan specific referral form to Disease Management programs.

SUBJECT: Individual Care Plan for Case Management **Policy #:** CM2
DEPARTMENT: Utilization Management

Effective Date: February 2005
Last Revision Date: June 20th 2025
Last Review: June 2026

SCOPE:

This policy applies to all lines of business including Medicare Special Needs Plan (SNP) members.

PURPOSE:

To define the process for developing and implementing an Individual Care Plan (ICP) for members in a case management program and Special Needs Plan program.

The ICP promotes the use of the least restrictive and most inclusive setting, as the member chooses, as appropriate to provide care in the least restrictive setting across the continuum of service providers including medical, behavioral health and long-term support services.

Effective no sooner than July 1, 2019, CalOptima shall assume responsibility for CCS for Members who are eligible for the California Children's Services [CCS] Program and transitioned into the Whole Child Model [WCM] program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions. Effective 7/1/2019, Individual Care Plans will be coordinated for members enrolled in the WCM program.

POLICY:

Members referred to the case management program will receive a timely and thorough assessment of their medical needs and social issues impacting the delivery of medical care as identified in CM1.

An ICP will be developed by the case manager in collaboration with the Interdisciplinary Care Team which also includes the member's designated Personal Care Coordinator (PCC) and will be based on the needs identified through the individual assessment process for each member referred to the case management program. Information may come directly from the member/parent and/or family/designated caregiver or legal representative. The development of the ICP will be based upon review of the following:

- Purpose of the referral, including assessment of member's health status and condition-specific issues
- Health Risk Assessments or Health Needs Assessment for WCM
- Clinical history including medications Activities of Daily Living
- Behavioral health status including cognitive functions.
- Psychosocial issues
- Life planning activities
- Cultural & Linguistic needs, preferences, or limitations
- Visual and hearing needs, preferences or limitations, Family support system/Caregiver resources and involvement
- Available benefits, benefit structure and community resources
- Member/care givers prioritized goals.
- Barriers to achieving the goals or complying with the plan.

- Referrals to services/resources and follow up to determine if services were provided.
- Self-management plan
- Age

SNP Care Plans will be reviewed at least annually by the Interdisciplinary Care Team or as often as the member's health and social status requires, ensuring ongoing improvement. Copies of the Care Plans are maintained in the member's records and copies distributed to the member and/or designated representative by mail and all participants of the ICT by system portal. Members/caregivers have access to all documentation and may request that the Care Plans be shared with providers in other care settings.

The member will participate actively in the development of his/her ICP within the limits of his/her physical and/or psychosocial capabilities.

Members, family, caregivers, PCP, specialists, a designated contact person will be identified for Behavioral Health related concerns and other members of the healthcare team involved in member's care will agree to the ICP prior to its implementation.

- In the event that a member refuses to participate in the case management program but is identified by the nursing and medical staff as needing the follow-up provided by the program (i.e., a high-risk patient), the health plan and the PCP will be contacted for assistance.

ICPs will be developed within 30 business days of a completed Health Risk Assessment (HRA) regardless of stratified Risk Level.

- For Health Net, partially completed HRAs will be treated as completed and the ICP will be developed within 30 working days or 45 calendar days. If no HRA is completed and the member stratified as high risk, the ICP is completed within 90 calendar days of the member's effective date. If no HRA is completed and the member is stratified as low risk, the ICP will be completed within 135 calendar days of the member's effective date.
- For CalOptima, the ICP will be developed within thirty (30) calendar days from posting of the completed HRA for Complex Case Management and Care Coordination and ninety (90) calendar days for Basic Population Health Management; or ninety (90) calendar days from the date of enrollment, whichever is earlier.

For Whole Child Model members, the Health Need Assessment [HNA]will be performed by the plan. ICPs will be completed within 60 days of receipt of the completed HNA and will include the preferences and SMART goals on behalf of the member to include but is not limited to, primary and specialty care services, mild to moderate or county mental health services, Early and Periodic Screening, Diagnosis and Treatment [EPSDT], Home Health Services, Regional Center services, County substance abuse disorder (SUD) or Drug Medical services where applicable and other medically necessary services provided within or out of network, when necessary.

The Care plan will be developed by care team in collaboration with the member/parent and/or family/designated caregiver and other program care givers such as Regional Center, Medical Therapy Program [MTP], Medical Therapy Unit [MTU], High Risk Infant Follow Up Program [HRIF], County CCS, etc. The Case Manager will ensure all service needs identified in the care plan are addressed including to but not limited to Primary and preventative care, specialty care, Medical Therapy Unit, EPSDT, Palliative Care, Regional Center and Home and Community Based services; and act as acts a central point of contact for questions related to healthcare

access, care concerns, and problem resolution. In accordance with the Model of Care requirements and WCM requirements, the ICP will be completed within 1 year for all transitioning members.

ICPs will be created and updated based on the member's needs and depending on the identified case management level. Complex and Care Coordination cases will be updated at a minimum of monthly to maintain current status. Basic cases will be monitored by key events and updated at a minimum of every six (6) months and annually.

The engagement of the members and/or their representatives plays an active role in designing their care plan. Case managers will allow the members to review the care plan and any amendments to their care plan. Care plans will be made available in alternate formats and in the member's preferred written or spoken language upon the member's request. Language assistance notifications will accompany all correspondence for multilingual members.

If a member is receiving behavioral health services, at least one (1) ICT case review meeting will include the Behavioral Health Provider, for their input and participation in the care planning process. Their participation will be clearly documented in the ICT meeting minutes, which includes a minimum of date of meeting, list of participants and evidence of creation and adjustments of care goals.

When a member participating in Case Management with an ICP and ICT is no longer eligible and/or transitions to another plan [or county as in the WCM], ICP and ICT data will be shared with the receiving entity according to plan policy. In some cases, the plan may require the information to be sent directly to the plan and the plan will coordinate with the new provider.

DEFINITIONS:

Age-Out Transition and Planning for WCM: Process of identification and plan for members who will require long-term health care needs beginning at age 14 and again at ages 16, 17, 18, 20 and 20 and 8 months.

Individual Care Plan: A plan of care developed after an assessment of the member's social and health care needs that reflects the member's resources, understanding of his/her disease process, and lifestyle choices.

Social Care Needs: Non-clinical needs relating to institutions and functioning of humans to meet basic needs, e.g., relationships, mental health status or food and shelter needs.

Special Need Plan [SNP]: A program of health care, services, and management for members that are dually eligible for Medicare and Medicaid benefits and services or institutionalized or institutional equivalent residing in the community or having certain CMS-approved severe or disabling chronic conditions.

PROCEDURE:

A. Every member accepted into the case management program will have a completed ICP.

B. The Case Manager uses evidenced based guidelines or algorithms to conduct assessment and management.

C. The ICP will identify:

1. Clear flexible and prioritized measurable objectives and target dates for completion to meet member's needs, level of care, including member and/or their representative's preferences and desired level of involvement in the case management program for medical, behavioral health and LTSS.

2. Specific recommendations for implementation

3. Contingencies for likely problems or barriers and/or complications that may develop in any elements of the ICP.

4. Member's strengths and capacity to complete the goals.

5. Development of self-management plan for member

6. Need for specific services/resources, as identified by the case manager, including but not limited to Behavioral Health resources, long term care needs such as Long-Term Support Services, In Home Support and Service (IHSS), Community Based Adult Services (CBAS), and Multi-purpose Senior Services (MSSP) referrals. Referrals will be made within the first 30 days of the completion of the assessment.

7. When a member has been identified as receiving behavioral health services, the name and contact information for their attending provider will be documented in the ICP.

8. Clinical interventions

9. Outcomes of interventions

D. The ICP will address:

1. Coordination of services among medical professionals, allied health professionals and community agencies and treatment options and/or alternate courses of care recommended by Physicians.

2. Utilization of accelerated and/or alternative care options when appropriate

3. Coordination and facilitation of in-patient, out-patient, and home care services

4. Provision of education/counseling to member and/or their representatives and family within the scope of the case managers licensure or scope of practice

5. Information on how family members and social support can be involved in care planning as per member and/or their representative's choice.

6. Behavioral health and long-term support needs determined.

E. For members in the Whole Child Model, the ICP will also identify and address:

a. Plan for continuous education, support, and information to members and/or their representatives.

b. Education on Primary Care Physician and Specialty Care Providers role, Care Management and care coordination and Continuity of Care needs, provisions of information about qualified professionals, community resources, process for specialized/customized DME needs, access to Maintenance and Transportation and other non-medical services needed, and/or other agencies for accessing services outside of County.

c. Age-out Transition and Planning for WCM members who will require long-term health care needs will begin at age 14 and will be re-assessed again at ages 16, 17, 18, 20 and 20 and 8 months and will include but not limited to evaluation of limitations of primary and specialty care providers currently seeing the member, the current condition and a plan to transition and track/monitor for 3 years following age out date.

d. Pediatric Provider Phase-Out Plan will begin at 19 years of age including those members previously identified with long term health care transition needs and will include but not limited to evaluation of limitations of primary and specialty care providers currently seeing the member, the current condition, and a plan to transition and track/monitor for 3 years following age out date.

F. Flexible prioritized goals will be documented. This will include:

1. Steps to be taken to achieve goals.

2. Timeframes to complete the goals.

3. Barriers identified in the member or representative/caregiver's ability to meet the goals and solutions to overcome the barriers.

4. Variances from goals

5. Identification of alternative actions taken to resolve care issues.

6. Steps taken to arrange for continuing care or alternative services and coordinated movement.

7. Transfer process to other agencies, entities, or facilities or back to the community per member and/or their representative's preference

8. Member and/or their representative's Education for healthy lifestyle changes

G. Resource and cost management will be addressed and confirmed by:

1. Documentation of utilization history

2. Referral to CCS, if appropriate

3. Referral to other pertinent agencies or programs such as: RCOC, HCA, WIC, etc.

H. The ICP will be updated and or reassessed based on the member's needs, case management level, and a change in health status or annually if no significant change in condition has occurred. Information to include:

1. Ongoing evaluation of progress toward stated goals
2. Ongoing evaluation of progress toward case closure
3. Outcome of interventions

I. The CM will sign and date all entries.

J. Evaluations will document:

1. Contacts with patient/family that includes responses.
2. Contacts with treating physician that includes responses or follow-up.
3. Contacts with healthcare team that includes responses.

K. A Registered Nurse (RN) or IPA Medical Director or his/her designee will sign all care plans.

L. The ICP will be distributed to all participants of the Individualized Care Team (ICT), in either the original form or copies and maintained in accordance with industry practices and State and Federal regulatory requirements for privacy, security, and preservation from destruction.

M. A Member Care Plan (MCP) will be mailed to the members and/or their representative as directed by the level of participation approved by the member.

N. Signed copies of the ICP will be obtained from the PCP and the Behavioral Health provider as an attestation of the review and approval of the plan. The signed ICP will be attached in the member's record.

O. The Case Management system captures the staff ID of the employee who makes changes in the members' medical record and the date and time. When care coordination data inaccuracies are identified they are amended by the employee and the system logs all field changes. Any system issue/glitch identified with locking fields are immediately reported to the Chief Information Officer. A report can be run that identifies all changes and updates made to the case management module and will include but is not limited to, original information, day/time of changes made, and the staff ID of the employee who made changes. The report function access is limited to designated management staff.

P. In the case of the WCM program where an intercounty transfer occurs, coordination will occur directly with CalOptima and will include but is not limited to a copy of the most recent ICP, clinical and relevant data including any admissions, open authorizations for last 6 months and most recent HNA.

FORMS:

None. All forms are within on-line system.

REFERENCES:

Policy and Procedure CM 1 – Case Management Assessment

SUBJECT: Case Management Assessment **Policy #:** CM1
DEPARTMENT: Utilization Management

Effective Date: February 2005
Last Revision Date: June 18th 2026
Last Review: June 2026

SCOPE:

This policy applies to all lines of business including Medicare Special Needs Plan (SNP) members.

PURPOSE

To define the process for assessing the health needs of a member referred to the case management program and Special Needs Plan program.

POLICY:

Members will be identified for Case Management services by the following avenues:

1. Practitioner referral
2. Member self-referral or Caregiver referral
3. Health Risk Assessments – Health Needs Assessments
4. UM referral.
5. Discharge Planning referral
6. Disease Management Program referral
7. Member Services referral.
8. Health Plan notice of prior Case Management case and/or for co-coordination which may include but is limited to historic data of UM, CM Assessments, IHSS, MSSP, SNF, BH and Pharmacy information.
9. Effective 7/1/2019, members currently enrolled in the Whole Child Model or newly enrolled members with California Children's Service [CCS] eligible conditions.

In addition, members may be identified from a review of:

1. Claims and encounter data
2. Hospital Discharge data
3. Pharmacy data
4. Data collected through the UM process.
5. Data supplied from purchasers, member's caregivers, or practitioners.
6. Data is supplied from health plans or eligibility lists for SPD members.

The same data in determining member eligibility for case management [above] will be utilized in the reassessment process as often as the member's health status dictates and at a minimum annually.

The Medicare SNP Health Plan is responsible for performing Health Risk Assessments [HRAs] for the members. These HRAs will be forwarded from the health plan to the IPAs with an acuity rating. The Case Managers will retrieve and review HRAs received from the plan daily. HRAs may be posted to the group FTP site or retrieved from a plan portal depending upon each individual plan's process for forwarding information. The information identified on the HRA will be used to develop an ICP for each member using evidence-based

clinical guidelines or algorithms to conduct assessment and management. If there is no HRA received from the health plan, the Case manager will educate the member and warm transfer to the health plan to complete the HRA.

The Interdisciplinary Care Team (ICT) has access to review claims and UM data. Routine review of these areas is done to ensure that ER, Acute and SNF admissions and discharge planning is incorporated into the care planning process. For Behavioral Health admissions, which are not a delegated function, the Case Managers will ensure that Behavior Health admissions are identified by coordinating care with the delegated party and updating care planning process to reflect partnership with the delegated parties. The Case Manager and PCC set 'Alerts' within the member's record to inform staff to notify the Case Manager of any activity.
Cases appropriate for Case Management will meet one or more of the following criteria:

1. Frail, chronically disabled, or significantly impaired (function and / or emotional).
2. Medically complex, long-term cases requiring multifaceted care.
3. Severely compromised by an acute episode of illness or an acute exacerbation of chronic illness with multiple hospital readmissions.
4. Living arrangements with environmental hazards and the absence of social support systems
5. Catastrophic injuries
6. Behavioral Health, to include Severely Emotionally Disturbed (SED) children or adolescents, including depression screening for all members (PHQ9).
7. Alcohol or Drug Abuse
8. Special needs, (i.e., Seniors and Persons with Disability, developmentally disabled, Early Start program, etc.)
9. Enrollment in the Whole Child Model.
10. Members diagnosed with feeding and eating disorders.

Members referred to, or already enrolled in specific agencies funded by county, state, or federal government, such as California Children's Services (CCS) will be case managed in coordination with those agencies to assure that there is appropriate care coordination.

For members who are diagnosed with feeding and eating disorders, where delegated, the IPA is responsible for providing Comprehensive Medical Case Management Services, including coordination of care, to ensure provision of all medically necessary services, whether those services are delivered within or outside of the IPA's provider network. These services are provided through either basic case, complex case or Enhanced Care Management activities based on the medical needs of the members. Where not delegated, the Case Manager will coordinate with the members' health plan for these services.

In cases where a newly eligible member has a prior Case Management treatment plan while under another group or health plan coverage, the Case Manager will make all attempts to contact the prior Case Manager for information to ensure coordination of care and ease of transition between the old plan and new plan.

Members have the right to accept or refuse participation in a case management program.

For Medi-Cal and Medicare programs, members also have the right to approve or disapprove of the authorized representatives who may be involved in the Interdisciplinary Care Team (ICT).

All members accepted into the case management program will receive a timely and thorough initial [per NCQA guidelines] and annual assessment of their medical needs and social issues impacting the delivery of medical care. These assessments will be based upon, but not limited to, the following elements:

- Member's health care status, including condition-specific issues.
- Documentation of Clinical history, including medications.
- Initial assessment of activities of daily living.
- Initial assessment of behavioral health status, including cognitive function.
- Initial assessment of psychosocial issues.
- Initial assessment of life-planning activities.
- Evaluation of cultural needs, health literacy, preferences, or limitations
- Evaluation of visual and hearing needs, preferences, or limitations
- Evaluation of caregiver resources or involvement
- Evaluation of benefits within plan or community resources
- Development of Individualized Case Management Plan, including prioritized goals, consideration of member and caregiver goals, preferences, and desired level of involvement in the care plan.
- Indication of barriers to meeting goals or complying with care plan.
- Medication reconciliation within 30 days of discharge.
- Identification of appropriate providers and facilities such as medical rehab, and support services to meet Member care needs.
- Facilitation of need for services/referrals/resources and follow up process to determine members act on referrals.
- Development of a schedule for follow-up and communication with members and/or caregivers and documentation when follow-up is not appropriate.
- Development and communication of member self-management plan
- Prognosis and process to assess progress against case management plans for members.
- Member preferences, strength and capacity and choices regarding treatments, services, and abilities
- Annual assessment of characteristics of individuals with disabilities and/or serious and persistent mental illness
- In addition to the above, cases in the Whole Child Model may also receive Age-Out planning, Pediatric to Adult Provider planning and/or Inter-County Transfer planning.

Timely turn-around times for processing referrals:

- Urgent referrals will be triaged within one (1) working day of receipt.
    - The member will be contacted within 1 business day to obtain consent for Care Coordination Case Management or Complex Case Management services.
    - Assessment and Individual Care Plan for the member will be developed within twenty-four hours of referral triage process.
- Standard referrals will be triaged within three (3) working days of receipt.
    - The members will be contacted within 5 business days to obtain consent for Care Coordination Case Management or Complex Case Management services.
    - Assessment of the member will be developed within five days of referral.
    - An Individualized Care Plan will be developed within ten days of the referral.

Case Managers will utilize current Apollo Clinical Guidelines or algorithms when developing Individual Care Plans and completing the assessment.

An individualized care plan will be developed that reflects the needs identified through the assessment process.

When the member is under the care of a Provider who has or will be terminating their participation with the group, the Case Manager will develop a transition of care plan immediately upon learning of a provider's intent to terminate ensuring coordination of care rules are met according to P&P UM29 Continuity of Care for Members Involuntarily Transitioning Between Providers.

DEFINITION:

Functional Status: A member's ability to manage activities of daily living such as bathing, feeding, and dressing themselves.

Medically Complex: The presence of a catastrophic illness and/or trauma, as well as an inability to manage that disease process or trauma.

Special Need Plan [SNP]: A program of health care, services, and management for members that are dually eligible for Medicare and Medicaid benefits and services or institutionalized or institutional equivalent residing in the community or having certain CMS-approved severe or disabling chronic conditions.

Targeted Case Management: [Defined by LA Care Health Plan]

1. Persons who have language or other comprehension barriers and
- **a.** Are unable to access or appropriately utilize services themselves.
- **b.** Have demonstrated noncompliance with their medical regimen.
- **c.** Are unable to understand medical directions because of language or other comprehension barriers; or
- **d.** Have no community support system to assist in follow-up care at home.

2. Persons who are 18 years of age and older and who
- **a.** Are on probation and have a medical and/or mental condition; or
- **b.** Have exhibited an inability to handle personal, medical, or other affairs; or
- **c.** Are under public conservatorship of person and/or estate; or
- **d.** Have a representative payee; or
- **e.** Are in frail health and in need of assistance to access services in order to prevent. institutionalization.

3. High-risk persons means those persons who have failed to take advantage of necessary health care services, or do not comply with their medical regimen or who need coordination of multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, substance abuse or because they are victims of abuse, neglect, or violence, including, but not limited to, the following individuals:

- **a.** Women, infants, children, and young adults to age 21
- **b.** Pregnant women.
- **c.** Persons with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
- **d.** Persons with reportable communicable disease
- **e.** Persons who are technology dependent. Solely for the purposes of the Targeted Case Management Services program, "technology dependent persons" means those persons who use a medical technology, embodied in a medical device, that compensates for the loss of normal use of a vital body function and require skilled nursing care to avert death or further disability.
- **f.** Persons with multiple diagnoses who require services from multiple health/social service providers.
- **g.** Persons who are medically fragile. Solely for the purposes of the Targeted Case Management Services program, "medically fragile persons" mean those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.

Targeted case management services shall include at least one of the following service components:

1. A documented assessment identifying the beneficiary's needs. The assessment shall support the selection of services and assistance necessary to meet the assessed needs and shall include the following, as relevant to each beneficiary: Cont. Definitions:

a) Medical/mental condition
b) Physical needs, such as food and clothing
c) Social/emotional status
d) Housing/physical environment
e) Familial/social support system
f) Training needs for community living
g) Educational/vocational needs

2. Development of a comprehensive, written, individual service, based upon the assessment specified in subsection (a) (1) above. An ICP shall be developed in consultation with the beneficiary and/or developed in consultation with the beneficiary's family or other social support system. The ICP shall be in writing and, as relevant to each beneficiary, document the following:

a) The nature, frequency, and duration of the services and assistance required to meet identified needs.
b) The programs, persons and/or agencies to which the beneficiary will be referred.
c) Specific strategies to achieve specific beneficiary outcomes.
d) Case manager's supervisor's signature

3. Implementation of the service includes linkage, consultation with, and referral to providers of service. The case manager shall follow up with the beneficiary and/or provider of service to determine whether services were received and whether the services met the needs of the beneficiary. The follow-up shall occur as quickly as indicated by the assessed need but shall not exceed thirty (30) days from the scheduled service.

a) Assistance with accessing the services identified in the service plan includes the following:
- Arranging appointments and/or transportation to medical, social, educational and other services.
- Arranging translation services to facilitate communication between the beneficiary and the case manager, or the beneficiary and other agencies or providers of service.

4. Crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary[For the target populations, crisis assistance planning shall be restricted to non-medical situations].

5. Periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should continue or be modified or discontinued. The review or reinvestigation shall be:

a) Completed at least every six months,
b) Conducted by the case manager in consultation with the beneficiary and/or in consultation with the beneficiary's family or social support system, and
c) Approved by the case manager's supervisor.
d) Any modifications to the plan of service shall be made in writing and become an addendum to the plan of service.

PROCEDURE:

A. A member's health needs may be assessed by Case Manager with the support of the Personal Care Coordinator (PCC):

1. Telephonic or on-site interviews with the member or his/her family.

2. Medical record review: including review of completed Initial Health Assessment (IHA) and the Initial Health Education Behavioral Assessment (IHEBA) and/or Health Risk Assessment (HRA) performed by the plan.

3. Multi-disciplinary meeting.

4. Consultation with the primary care provider, specialist, and their ancillary staff.

5. Consultation with health plan staff.

6. Consultation with a community agency and discussion of referral needs.

7. Specialty DME needs, transportation needs, etc. [For members in the Whole Child Program, transportation and maintenance services will be coordinated with CalOptima. See P&P UM30 Transportation Services]

B. The case assessment will be documented on contact in the assessment forms and will include the following information:

1. Member name, address, and phone number and preferred language and cultural needs

2. Preference for participation and involvement by Caregiver, providers, etc.

3. Identification number

4. Contact numbers for member, caregiver or member designated family.

5. Age

6. Marital status

7. Living arrangements

8. Date assessed.

9. Pertinent medical history

10. Behavioral health status including cognitive functioning with a focus on the Recovery Model

11. Name of physician/specialists

12. Medications/allergies

13. Activities of daily living/Instrumental activities of daily living (ADL/IADL) status

14. Durable medical equipment

15. Systems review

a. Circulatory
b. Cardiac
c. Pulmonary
d. Muscular/Skeletal
e. Integumentary
f. GI
g. GU
h. Endocrine
i. Neurologic
j. GYN
k. Vision
l. Hearing

16. Assessment of Life Planning activities [i.e., Advanced Directives or Durable Power of Attorney]

17. Assessment of resources, available benefits, provide education to the member about the benefits, assist with enrollment, and follow up with the outcome of the referral for services including but not limited to Long Term Care, Long Term Support Service, Community Based Adult Services (CBAS), In Home and Support Services (IHSS) including education on the member's right to self-direct, hire, fire, and manage the IHSS provider, and Multi-purpose Senior Services (MSSP) for Medi-Cal, Medicare and members. For Whole Child Model members, this may also include education to Parents/Caretaker regarding coordination of care with Health Plan, County CCS Health Care Manager, Regional Center Care Manager, High Risk Infant Follow up Program [HRIF], Medical Therapy Program [MTP], Medical Therapy Unit [MTU], EPSDT, including palliative care services.

18. Appropriate care setting to meet member needs.

19. Plan for frequency of contact according to member needs

20. Assessment of C&L needs, preferences, and limitations.

21. Signature of case manager (CM) or CM's name on electronic forms

C. The case manager will develop a care plan that reflects the needs identified through the assessment process, including member preferences and choices regarding treatments, services and abilities. Care plans for Whole Child Model members may be coordinated in conjunction with their other Specialty Care Providers and Care Managers with Regional Center, County CCS, Medical Therapy Unit, Medical Therapy Program and Health Plan.

D. The CM and the PCC will facilitate and provide coordination of care for recommended services that include but are not limited to medical, behavioral health and LTSS (MSSP, CBAS, IHSS, SNF). Services requiring an authorization or referral to an outside partner (Behavioral Health and Drug MediCal) the CM and PCC will coordinate care for those services and ensure appropriate services are reviewed at the appropriate agency and implemented as indicated.

E. Members and/or their Caregiver participating in Case Management activities will receive all necessary information regarding treatment and services so that they may make an informed choice.

F. When the IPA has identified a member who may benefit from CM services for disease management related issues or due to any high risk, if the IPA is not delegated for CM and/or only delegated for specified levels of CM, the IPA will notify the health plan telephonically or via fax within 2 business days of identification. All related documentation will be forwarded to the Health Plan via fax.

G. The Case Management Level (CML) will be determined based on the conditions identified in the assessment process, member's preference of the level of participation in the case management process and or intensity of case management interventions.

H. Re-Assessments will be performed as often as the health status, functional status, or social needs of the member requires and at least annually and/or upon receipt of the annual HRA. Reasons for reassessment will be documented. First consideration will be given to the member's preference when determining the mode by which the updates will be completed.

FORMS:
None. All forms are within on-line system

REFERENCES:
None required

CLAIMS AND BILLING GUIDELINES

NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY

Claims and Encounters Process

Noble's claims department provides efficient and prompt claims processing services for our contracted IPA's, Managed Hospitals and provides claims adjudication in contract agreements. Our experienced staff at Noble is familiar with Medicare (CMS), Medi-Cal, Healthy Families and Commercial regulatory requirements, including claims timeliness guidelines to ensure claims are processed accordingly. Noble is able to specifically customize clients' payments based on the clients Health Plan contracts, provider contracts, member eligibility and member benefits.

Our state of the art claim system is able to log, adjudicate and pay claims. Our system automates most of the processing to allow greater accuracy and faster claim turnaround time. Our systems are able to read the information and automatically load it into our claims system.

Noble has the capability to receive claims electronically through our partnership with Office Ally or using an 837-electronic format for direct in loads from our FTP site. In addition, Noble uses its own remote access claim system ("HealthSmart Web") and our Practice Management Module that allows Providers to submit claims electronically for even faster claims turnaround time.

Noble remote access system allows providers to review the status and history of their claims and payment online for quick and easy access. The integrated data loading capabilities of Noble claims systems allows our claims processors to manually enter only a minimal amount of data, which maximizes daily production.

Our claims staff actively pursues recoveries on behalf of our clients. Most importantly, our Claims Department is committed to providing timely and courteous Customer Service Responses. Our payment turnaround times consistently fall within accepted industry benchmarks, and we conduct back-end claims audits to avoid overpayment of claims and ensure that each claim is paid according to contracted rates. Noble supports in-house recovery procedures to identify and recover lost money on insured services, reinsurance, overpayments, Third-party liability, coordination of benefits, and retroactive terminations.

Submission of Claims

Electronic via Office Ally: Payer ID Code **HSM01**

Hard Copy Claims: CM1500/UB04/PM160

Please submit all claims and encounter data reports to:

Noble Community Medical Associates, Inc. of Mid-Orange County

Attention: HSMSO- Claims Department
P.O. Box 6301
Cypress, CA 90630-0018

Claims Department

Telephone: (714) 947-8600
Fax: (714) 947-8725

Monday- Friday: 8:00AM- 5:00PM PST

Timely Filing

- Contracted providers must bill all claims within 90-days from the date of service
- Non-contracted providers must bill all claims within 180-days from the date of service

PATIENT ENCOUNTER REPORTS

Capitated Services

After a Noble patient is treated by a PCP, your office must complete an ENCOUNTER FORM. All contracted Health Plans absolutely require encounter reporting on all services rendered to their members.

Encounter forms for each patient visiting must be mailed or faxed to the IPA's administration office no later than the 10th day following the end of the month. You may use the Encounter form provided by the IPA's administration Office or a CMS 1500 clearly marked "Encounter Data."

It is important that your office fully completes an encounter form for each patient and to be certain to list all the services you provided.

Non-Capitated Services

Services provided to patients (i.e. commercial patient immunization agents) that are not covered by capitation **should** be listed on the Encounter Form but a separate CMS 1500 form should be mailed to HealthSmart MSO administration office for reimbursement. You can also mark your encounter form or CMS 1500 form as a claim so your claim can be identified and paid.

For additional information, please visit:

- HealthSmart MSO: http://healthsmartmso.com/hsmso-services/claims/

NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY

Claims Settlement Practices and Dispute Resolution

As required by Assembly Bill 1455, the California Department of Managed Health Care (DMHC) has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the DMHC. This information notice settlement practices and claims disputes for commercial HMO, POS, and where applicable. Where Noble is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

Claims Submission Instructions:

Sending Claims to Noble. Claims for services provided to members assigned to Noble must be sent to the following:

1. Via Mail:
   Noble Community Medical Associates, Inc. of Mid-Orange County
   Attention: HSMSO- Claims Department
   P.O. Box 6301
   Cypress, CA 90630-0018

2. Via Physical Delivery:
   Noble Community Medical Associates, Inc. of Mid-Orange County
   C/O HealthSmart MSO, Inc.
   5785 Corporate Avenue
   Cypress, CA 90630-0018

3. Via Fax: (714) 947-8725

4. Via Electronic Submission: Office Ally
   Payer ID: HSM01

Calling Noble Regarding Claims. For claim filing requirements or status inquiries, you may contact Noble by calling: (714) 947-8600.

Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by Noble:

1. Medical Records (i.e. Ops reports/Anesthesia reports, etc.)
2. Copy of approved Authorization Request

Claims Receipt Verification. For verification of claim receipt by Noble, please do the following:

Call: (714) 947-8600

Fax inquired to: (714) 947-8725

Dispute Resolution Process for Contracted Providers

Definition of Contracted Provider Disputes. A contracted provider dispute is a provider's written notice to Noble and/or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name, provider's identification number, provider's contact information, and:

If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim for Noble to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's positions on such issue; and

If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification numbers(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

Sending a Contracted Provider Dispute to Noble. Contracted provider disputes submitted to Noble must include the information as mentioned in above for each contracted provider dispute. All contacted provider disputes must be sent and attention of **CLAIMS DEPARTMENT** at Noble at the following:

Via Mail:

Noble Community Medical Associates, Inc. of Mid-Orange County
C/O: HealthSmart MSO, Inc.
P.O. Box 6301
Cypress, CA 90630-0018
ATTN: Claims Manager

Via Physical Delivery:

Noble Community Medical Associates, Inc. of Mid-Orange County
C/O: HealthSmart MSO, Inc.
5785 Corporate Avenue
Cypress, CA 90630-0018
ATTN: Claims Manager

Via Fax: (714) 947-8725- Attn: Claims Manager

Time Period for Submission for Provider Disputes.

i. Contracted provider disputes must be received by Noble within **365-days** from provider's action that led to the dispute (or the most recent action is there are multiple actions) that led to the dispute, or

ii. In the case of inaction, contracted provider disputes must be received by Noble within **365- days** after the provider's time for contesting or denying a claim (or most recent claim If there are multiple claims) had expired.

iii. Contracted provider disputes that do not include all required information as set forth above section, may returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to Noble within thirty (30) working days of your receipt of a returned contracted provider dispute.

Acknowledgment of Contracted Provider Disputes. Noble will acknowledge receipt of all contracted provider disputes as follows:

Electronic contracted provider disputes will be acknowledged by Noble within two (2) working days of the date of receipt by Noble.

Paper contracted provider disputes will be acknowledge by Noble within fifteen (15) working dates of the date of receipt by Noble.

Contact Noble Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to Noble at: **(7140 947-8600.**

Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batched as a single dispute, provided that such disputes are submitted in the following format:

- Sort provider disputes by IPA/Medical Group
- Provider cover sheet for each IPA/Medical Group

- Provide proof of timely filing
- Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets

Time Period for Resolution and Written Determination of Contracted Provider Dispute. Noble will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider. Noble will pay and outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

Dispute Resolution Process for Non-Contracted Providers

Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to Noble challenging, appealing or requesting reconsideration of a claim (or bundled group of substantially similar claims that are individually numbered) that have been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Noble to provide the following must be provided: a clear identification of the disputed item, the date of service and a clear explanation of the basis upon which the provider believed the payment amount request for additional information, contest, denial, request for reimbursement for the over payment of a claim, or other action is incorrect;

ii. If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the date of service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in the above section.

Claims Overpayments

Notice of Overpayment of a Claim. If Noble determines that it has overpaid a claim. Noble will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service(s) and a clear explanation of the basis upon with Noble believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Contested Notice. If the provider contests Noble's notice of overpayment of a claim, the provider, within thirty (30) workings days of the receipt of the notice of overpayment of a claim, must send written notice to Noble stating the basis upon which the provider believes that the claim was not overpaid. Noble will process the contested notice in accordance with Noble's contracted provider dispute resolution process described in the sections above.

No Contest. If the provider does not contest Noble's notice of overpayment of a claim, the provider must reimburse Noble within thirty (3) working days of the provider's receipt of the notice of overpayment of a claim.

Offset to Payments. Noble may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider failed to reimburse Noble within the timeframe set forth in the section above, and (ii) Noble's contract with the provider specifically authorizes Noble to offset an uncontested notice of overpayment of a claim form the provider's current claims submission. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, Noble will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claims or claims.

For additional information and a copy of the provider dispute resolution form, please visit:

- HealthSmart MSO: http://healthsmartmso.com/hsmso-services/claims/

SUBJECT: Claims Submission **Policy #:** CLM002
DEPARTMENT: Claims

Effective Date: November 2013
Last Revision:
Last Review Date: January 2016, January 2017, January 2022, January 2023

SCOPE:
This policy applies to all Lines of Business.

PURPOSE:
To provide a policy establishing claims submission timelines and corresponding procedures for claim submission review.

POLICY:
It is the policy of Health Smart, MSO to ensure that claim submission timelines are in place and that no timeframe for submission is less than 90 days following the date of service for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. Claims submission timelines shall be in accordance with CCR § 1300.71, and Medicare Advantage regulations as forth by the Centers for Medicare and Medicaid Services.

PROCEDURE:

1. Contracted provider claims submitted greater than 90 days following the date of service will be denied for untimely submission unless otherwise defined in the provider's contract.

2. Commercial claims submitted greater than 180 days following the date of service from non- contracted providers will be denied for untimely submission.

3. Non-contracted Medi-Cal claims submitted greater than 6 months following the month of service will be subject to reduction in payment or denial. Claims received in the 7th through the 9th month following the month of service will be reduced in payment by 25%. Claims received in the 10th through the 12th month following the month of service will be reduced in payment by 50%. Claims received after 12 months following the month of service will be denied for untimely submission.

4. Non-contracting providers billing for Medicare members are required to bill according to federal regulation: Effective January 1, 2010 claims for services dates on or after January 1, 2010, must be filed within one calendar year after the date of service. Claims received beyond the one calendar year will be denied for untimely submission.

5. Claims not received within these timeframes are subject to denial or reduction

Adriana Regalado
Vice-President of Claims - 1/2021

in payment.

6. If the medical group/IPA is secondary payer under coordination of benefits, the period begins on the date the primary payer has issued payment or denial on the claim.

7. Late submission of claims will be accepted when demonstration of good cause for the delay of submission has been established.

Adriana Regalado

Vice-President of Claims - 1/2021

SUBJECT: Forwarding Misdirected Claims **Policy #:** CLM006
DEPARTMENT: Claims

Effective Date: January 2006
Last Revision: November 2014
Last Review Date: 2018,
January 2021, January 2023

SCOPE:
This policy applies to All Lines of Business

PURPOSE:
To identify claims that are not the financial responsibility of the assigned Medical Group/IPA and forward to the responsible party within ten **(10) working days** of the receipt of the claim, pursuant to California regulatons for Medi-Cal and Commercial lines of business and within ten **(10) calendar days** for Medicare line of business pursuant to Center for Medicare and Medicaid Services (CMS) requirements.

POLICY:
It is the policy of HealthSmart MSO (HSMSO) to ensure timely forwarding of misdirected claims and to maintain a log of all misdirected claims.

PROCEDURE:

If a claim is received and determined that it is NOT the financial responsibility of the Medical Group/IPA or Capitated Hospital that is managed by HealthSmart, MSO, the Claims Examiner will:

1. Have the claim entered and acknowledged within timeframes set forth by line of business regulation. The system will automatically flag claims that are not the financial responsibility of the medical group or HSMSO.
2. A report "Misdirected Claims Report" is generated daily.
3. The claims are reviewed to ensure that the claims are not the financial responsibility of the medical group.
4. The claims will be denied **B11 - "Claim forwarded to Health Plan/Capitated Hospital"** or **"109 -Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor."**
5. If the claim involves non-emergent contracted services, it shall be denied, notifying the provider of the responsible.
6. If the claim involves non-emergent non-contracted services, it shall be denied **B11 - "Claim forwarded to Health Plan/Capitated Hospital"** or **"109 -Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor."**
7. An EOP (Explanation of Payment), which is the remittance advice used by HSMSO, will be generated and mailed to the provider so they may follow up with the appropriate party for any payment inquiries.
8. For Humana Health Plan: Humana claims that are not the financial responsibility of

Adriana Regalado
Vice-President of Claims - 1/2021

the IPA must be forwarded to Humana, Claims Center Point, 1 Park Plaza, Ste. 450, Irvine, CA 92614.

SUBJECT: Clean Claim **Policy #:** CLM007
DEPARTMENT: Claims

Effective Date: January 2006
Last Revision: January 2013
Last Review Date: January 2016, January 2017, April 2018, January 2021, January 2023

SCOPE:
This policy applies to All Lines of Business.

PURPOSE:
To identify Unclean claims, in which additional data must be supplied by the provider in order to properly adjudicate the claim.

POLICY:
HealthSmart, MSO processes "clean claims" according to the Centers of Medicare Services, regulatory and contract requirements. The Claims Department will process all "other-than-clean" claims and notify the provider of the claims determination within **30** calendar days of receiving the claim. The timeline for claims determination for Medi-Cal Line of Business is **30** calendar days and **45** business days for Commercial Line of Business.

Claims that do not meet the definition of "clean" claims are classified as "other-than-clean" claims, and "other-than-clean" claims require investigation or development outside of HSMSO's operation on a prepayment basis.

Examples are claims on which HSMSO:

- Requests additional information from the provider or another external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies
- Requests information or assistance from another contractor. This includes requests for charge data from the carrier, or any other request for information from the carrier
- Develops Medicare Secondary Payer (MSP) information
- Requests information necessary for coverage determination
- Performs sequential processing when an earlier claim is in development

"Clean claim" means a claim that does not contain a defect requiring HSMSO to investigate or develop prior to adjudication. Clean claims must be filed within the timely filing period.

"Other-than-clean claim" is a claim that does not meet the definition of "clean claim" above. These are complete claims that require manual intervention on the part of HSMSO to be

Adriana Regalado
Vice-President of Claims - 1/2021

adjudicated.

For electronic claims submission, a claim is considered "other-than-clean" if it is not in the HIPAA approved 837 file format.

DEFINITION:

A "clean claim" is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-contracting providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim (Section I842(e)(2)(B) of the Social Security Act).

A "clean claim" is a claim submitted on either a CMS 1500, or UB 04, and is one that can be processed without obtaining additional information from the practitioner, provider of service or a third party. A "clean claim" includes all attachments and supplemental information or documentation which provides reasonably relevant information or information necessary to determine payer liability. The information for a clean claim may vary somewhat based on the type of practitioner or provider of service.

The following information must be included on every claim form for the claim to be considered complete:

- Provider name and address;
- Member name, date of birth, and social security number;
- Date(s) of service;
- Diagnoses code(s);
- Revenue, CPT, or HCPCS;
- Billed charges for each service or item provided;
- Place of service or UB92 bill type;
- Provider Tax ID number and/or social security number;
- Name and state license number of attending physician; and
- NPI number

Although emergency services or out-of-area urgently needed services do not require authorization in order to be considered "complete", the claim must include:

- A diagnosis which is immediately identifiable as emergent or out-of-area urgent, and;

For Medi-Cal and Commercial Lines of Business with incomplete information, the claim will be denied stating what information is lacking. When the information is received, the claim will be processed as a new claim.

Claims suspended for additional information from the provider or sources **outside** of HSMSO and its affiliates are considered "non-clean claims." Claims suspended for information from the Provider Contracting Department, Utilization Management, Membership Services or other sources **within** HSMSO are still considered "clean claims."

Adriana Regalado

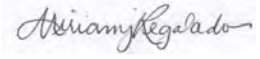
Vice-President of Claims - 1/2021

8. NON-CLEAN CLAIMS: Medicare

- If HSMSO receives a claim that lacks required information, it shall change the claim status to "pend" status.

- HSMSO shall notify a Provider of a Non-Clean Claim no later than thirty (30) working days after the date or receipt, in writing, with a request for the missing information.

- If HSMSO requests Reasonably Relevant Information from a Provider in addition to information that the Provider submits with a claim, HSMSO shall provide a written explanation of the necessity for such request.



SUBJECT: Claims Adjudication Process and Timeliness **Policy #:** CLM011

DEPARTMENT: Claims

Effective Date: November 2013
Last Revision: November 2014
Last Review Date: January 2016, January 2017, April 2018, January 2021, January 2023

SCOPE:
This policy applies to all Lines of Business.

PURPOSE:
To provide a general and linear procedure for the timely processing and adjudication of claims.

POLICY:
It is the policy of HealthSmart Management Service Organization (HSMSO) to ensure that claims are adjudicated and processed timely.

PROCEDURE:

1. Claims management sorts claims by type of service
   a. Physician Claims (Office, ER, Inpatient, Outpatient)
   b. Facility Claims (Inpatient, Outpatient, ER, Surgery and Diagnostic)
   c. DME
   d. Ambulance
   e. P/T & O/T

2. Verify Eligibility via Health Plan website, Medi-Cal, Medicare or CalOptima
   a. Write the coverage (Commercial, Medi-Cal, Medicare, Cal MediConnect) and the enroll date on the claim.
   b. If the member is termed, enter the termed date on the claim as well.

3. Verify Authorization
   a. Write the authorization# on the claim. If the provider has an authorization# on the claim, verify it with the IPA then have UM enter a percent into EHEALTHCARE.

4. Determine Completeness of Claim
   a. Prior to adjudication the adjuster needs to make certain that the provider has billed with all of the pertinent information necessary for claim adjudication. Such as, valid CPT, diagnosis and place of service codes, provider's name, tax ID and medical license number.

5. Note Authorization Comments on Claim
   a. If the patient has CCS, write the CCS case & auth#'s on the claim prior to

Adriana Regalado
Vice-President of Claims - 1/2021

adjudicating the claim.

b. If the claim is for OB, note whether it was a vaginal or C-section delivery.
c. Make sure the admit and discharge dates on the claim match the authorization dates in eHealthcare.

6. Calculate Rate of Payment
   a. Separate claims by contracted and non-contracted providers. For the contracted providers write the contracted amount on the claim for adjudication. Separate the remaining claims by line of business.
   b. Pay non-contracted Medi-Cal claims at the prevailing/current Medi-Cal rate at the time of service. For contracted providers, pay the contract rate.
   c. Pay non-contracted Medicare at the prevailing/current Medicare rate at the time of service. For contracted providers, pay the contract rate.
   d. Pay non-contracted Commercial claims at 125% of prevailing/current Medicare rate at the time of service for Korean American Medical Group.
   e. Pay non-contracted California Marketplace claims at the prevailing/current Medi-Cal rate at the time of service. For contracted providers, pay the contract rate.

7. Adjudication of Clean Claims
   a. Enter claims by the received date stamped on the claim. Always use HSMSO, Inc.'s received date for Medi-Cal and Commercial claims. **Use the oldest received date for Medicare claims.**
   b. By entering the authorization number showing on the claim into EHEALTHCARE, the system will automatically enter the correct member name, ID# and provider information. Verify that this information is correct before proceeding.
   c. Make sure that all the correct diagnosis codes on the claim are entered into the system.
   d. Enter the date of service, the place of service, and billed amount. The system will automatically go to the correct fee schedule according to the member's eligibility. Make certain if the claim is for a Commercial or Medicare Program member, you enter the applicable co-payment amount for accurate reimbursement.
   e. After the entire claim has been entered, verify the information to make sure everything has been data entered correctly before you proceed to your next claim.

8. Unclean Claims
   a. Contracted Providers:
      - A Claim lacking any of the information above is considered incomplete, and will be developed for the missing information.
      - A letter is generated to the provider requesting the identified missing information within thirty (30) days of receipt of claim, and the claim is flagged in the system as **"UNCL"** – Unclean.
      - If the information is not received by the 40th day, a second Pend Letter is generated to the provider requesting the additional information.
      - If IPA does not receive the requested information within fifty-five (55)

Adriana Regalado

Vice-President of Claims - 1/2021

calendar days after it receives the claim, IPA shall review the claim with the information available and shall make an initial determination to pay or deny the claim no later than **sixty (60) calendar days.**

- If the information is received between the 55th and 60th day, the claim is re-opened utilizing the original received date and processed for adjudication.
  If the information is received after the 60th day, the claim is re-opened utilizing the new received date. (The new receipt date is based on the day when the requested information is received).

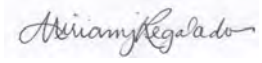
b. Non-Contracted Providers:
   - A Claim lacking any of the information above is considered incomplete, and will be developed for the missing information.
   - A letter is generated to the provider requesting the identified missing information within thirty (30) days of receipt of claim, and the claim is flagged in the system as **"UNCL"** – Unclean.
   - If the information is not received by the 40th day, a second Pend Letter is generated to the provider requesting the additional information.
   - If IPA does not receive the requested information within fifty-five (55) calendar days after it receives the claim, IPA shall review the claim with the information available and shall make an initial determination to pay or deny the claim no later than **sixty (60) calendar days.**
   - If the information is received between the 55th and 60th day, the claim is re-opened utilizing the original received date and processed for adjudication.
   - If the information is received after the 60th day, the claim is re-opened utilizing the new received date. (The new receipt date is based on the day when the requested information is received).
   - The claims examiner shall reprocess the pended claim upon receipt of the requested information in accordance with the timelines set forth in this policy.

NON-CLEAN CLAIMS: Commercial

A Claim lacking any information for adjudication is considered incomplete and unclean, and will be contested within 45 working days.

NON-CLEAN CLAIMS: Medi-Cal

A Claim lacking any information for adjudication is considered incomplete and unclean, and will be contested within 30 working days.



Vice-President of Claims - 1/2021

NON-CLEAM CLAIMS: Covered California
A Claim lacking any information for adjudication is considered incomplete and unclean, and will be contested within 45 working days.

NON-CLEAN CLAIMS: Medicare

- If IPA receives a claim that lacks required information, it shall change the claim status to "pend" status.

- HSMSO shall notify a Provider of a Non-Clean Claim no later than thirty (30) working days after the date or receipt, in writing, with a request for the missing information. If HSMSO requests Reasonably Relevant Information from a Provider in addition to information that the Provider submits with a claim, HSMSO shall provide a written explanation of the necessity for such request.

SEE ATTACHED "COMPLETE CLAIMS" PROCESSING GUIDE FOR CALIFORNIA

REFERENCES:
"Complete Claims" Processing Guidelines for California (ICE Approved 9-19-03 and still current)

Adriana Regalado
Vice-President of Claims - 1/2021

SUBJECT: Claims Processing and Settlement Practices **Policy #:** CLM012

DEPARTMENT: Claims

Effective Date: November 2001
Last Revision: December 2006; January 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; November 2013, December 2014, March 2015, April 2015, May 2015
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021 , January 2023

SCOPE:
This policy applies to All Lines of Business.

PURPOSE:
To ensure timely and accurate claims payment in concert with contractual obligations, and compliance with applicable State and Federal regulations.

POLICY:
It is the policy of HealthSmart Management Service Organization (HSMSO) to ensure ongoing compliance with California regulations governing claims payments, including 28 CCR Rule 1300.71, and CMS and Medicare Advantage regulatory requirements and guidelines. Further, it is the policy of HSMSO to provide a procedure for reviewing the CMS website (www.cms.gov) on at least a quarterly basis to ensure the most updated forms, policies and procedures are being utilized.

See attached "Complete Claims Processing Guidelines for California."

1. HSMSO shall not impose a deadline for the receipt of a claim that is less than ninety (90) days for contracted providers and one hundred and eighty (180) days for non-contracted providers after the Date of Service and shall forward misdirected claims in accordance with provisions of this policy.

2. HSMSO shall establish administrative processes, or contract with an organization to accept and adjudicate claims for health care services provided to members in accordance with contractual, regulatory and statutory requirements.

3. HSMSO shall maintain a claims retrieval system that can identify and acknowledge the date of receipt, whether or not it was a Clean Claim, the action taken on all provider claims (i.e. paid, denied, pended) and the date the action was taken, in the same manner as the claim was submitted.

4. Further, it is the policy of HSMSO to ensure that any policy and procedure must be presented to the Plan at least 30 days in advance of proposed update allowing the Plan to review and approve said change(s) prior to implementation. HSMSO shall track all submissions and approvals to ensure compliance.

Adriana Regalado
Vice-President of Claims - 1/2021

5. HSMSO shall not improperly deny, adjust, or contest a claim and shall provide a clear and accurate written explanation of the specific reasons for the action taken. HSMSO may contest or deny a claim, or portion thereof, by notifying the provider, in writing, that the claim is contested or denied, within timeframes set forth in the provisions of this policy.

6. HSMSO shall not request reimbursement for overpayment of a claim, unless it sends a written Request for Reimbursement to the provider within three hundred and sixty-five (365) days after the Date of Payment of the overpaid claim.

7. HSMSO shall establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes pursuant to both Rule 1300.71 and Medicare regulations.

8. In accordance with provisions of this policy, at the time of initial contracting, and on an annual basis, and upon a contracted providers' written request, HSMSO shall provide the following information in a paper or electronic format, which may include a website containing this information, or another mutually agreeable accessible format:

    a. Directions for claims inquiries and filing information;
    b. The identity of the office responsible for receiving and resolving provider disputes;
    c. Directions for provider dispute inquiries and filing information;
    d. Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single provider dispute that includes a numbering scheme identifying each dispute contained in the bundled cases;
    e. Complete fee schedule for the contracting provider;
    f. Detailed payment policies and procedures and rules and non-standard coding methodologies used to adjudicate claims;

9. HSMSO shall provide a minimum of forty-five (45) days prior written notice before instituting any changes, amendments, or modification in the disclosures pursuant to the preceding information.

10. HSMSO shall monitor claim production and accuracy ratios to ensure ongoing timeliness and quality of claims operations.

11. HSMSO shall submit required claims performance reports within thirty (30) days after the close of each reporting period in the format required by the health plan.

CLEAN CLAIMS: MEDICARE

HSMSO shall reimburse each Complete Claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) calendar days for Non-Contracted Medicare providers and no later than sixty (60) calendar days for Contracted Providers, after the date of receipt of the claim from the provider, unless the Complete Claim or portion thereof is contested or denied, in accordance with provisions of this policy.

CLEAN CLAIMS: Cal MediConnect

HSMSO shall reimburse each Complete Claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) calendar days for Cal MediConnect Line of Business.

CLEAN CLAIMS: Cal MediConnect (CALOPTIMA)
HSMSO shall reimburse each Complete Claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) calendar days for Cal MediConnect Line of Business. **HSMSO must pay interest on clean claims that are not paid within 30 calendar days.** HSMSO will ensure that ninety percent (90%) of claims which can be processed without obtaining additional information from the physician of from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine percent (99%) of clean claims from Covered Service Providers will be paid within ninety (90) days of the date of receipt of the claim.

CLEAN CLAIMS: Medi-Cal
HSMSO shall reimburse each Complete Claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) calendar days for Medi-Cal Line of Business.

CLEAN CLAIMS: Commercial
HSMSO shall reimburse each Complete Claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than forty-five (45) business days for Commercial Line of Business.

NON-CLEAN CLAIMS: Commercial
A Claim lacking any information for adjudication is considered incomplete and unclean, and will be contested within 45 working days.

NON-CLEAN CLAIMS: Medi-Cal
A Claim lacking any information for adjudication is considered incomplete and unclean, and will be contested within 30 working days.

NON-CLEAN CLAIMS: Cal MediConnect
All claims must be appropriately developed prior to denial. Development is defined as the need to contact an outside source for additional information prior to making the decision to pay or deny the claim.

NON-CLEAN CLAIMS: Medicare

1. If HSMSO receives a claim that lacks required information, it shall change the claim status to “pend” status.

2. HSMSO shall notify a Provider of a Non-Clean Claim no later than thirty (30) working days after the date or receipt, in writing, with a request for the missing information. If HSMSO requests Reasonably Relevant Information from a Provider in addition to information that the Provider submits with a claim, HSMSO shall provide a written explanation of the necessity for such request.



3. Contracted Providers:
    - A Claim lacking any of the information above is considered incomplete, and will be developed for the missing information.
    - A letter is generated to the provider requesting the identified missing information within thirty (30) days of receipt of claim, and the claim is flagged in the system as **"UNCL"** – Unclean.
    - If the information is not received by the 40th day, a second Pend Letter is generated to the provider requesting the additional information.
    - If HSMSO does not receive the requested information within fifty-five (55) calendar days after it receives the claim, HSMSO shall review the claim with the information available and shall make an initial determination to pay or deny the claim no later than **sixty (60) calendar days.**
    - If the information is received between the 55th and 60th day, the claim is re-opened utilizing the original received date and processed for adjudication.
    - If the information is received after the 60th day, the claim is re-opened utilizing the new received date. (The new receipt date is based on the day when the requested information is received).

4. Non-Contracted Providers:
    - A Claim lacking any of the information above is considered incomplete, and will be developed for the missing information.
    - A letter is generated to the provider requesting the identified missing information within thirty (30) days of receipt of claim, and the claim is flagged in the system as **"UNCL"** – Unclean.
    - If the information is not received by the 40th day, a second Pend Letter is generated to the provider requesting the additional information.
    - If HSMSO does not receive the requested information within fifty-five (55) calendar days after it receives the claim, IPA shall review the claim with the information available and shall make an initial determination to pay or deny the claim no later than **sixty (60) calendar days.**
    - If the information is received between the 55th and 60th day, the claim is re-opened utilizing the original received date and processed for adjudication.
    - If the information is received after the 60th day, the claim is re-opened utilizing the new received date. (The new receipt date is based on the day when the requested information is received).

5. The claims examiner shall reprocess the pended claim upon receipt of the requested information in accordance with the timelines set forth in this policy.

DEFINITIONS:

Automatically: The payment of the interest due to the provider shall be made no later than five (5) working days after the payment of the claim without the need for any reminder or request by the provider.

Adriana Regalado

Vice-President of Claims - 1/2021

1. If the interest payment is not sent in the same envelope as the claim payment, HSMSO shall identify the specific claim or claims for which the interest payment is made, include a statement setting forth the method for calculating the interest on each claim, and document the specific interest payment made for each claim.

2. In the event that the interest due on an individual late claim payment is less than $2.00 at the time the claim is paid, HSMSO may pay the interest on that claim, along with interest on other such claims within ten (10) calendar days after the close of the calendar month in which the claim was paid, provided HSMSO includes with the interest payment a statement identifying the specific claims for which the interest is paid, setting forth the method for calculating interest on each claim, and documenting the specific interest payment made for each claim.

Complete Claim: A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides "reasonably relevant information," "information necessary to determine payer liability" and varies somewhat based on the type of provider.

1. Provider claims for services rendered to a patient who was provided emergency services and care in the United States on or after September 1, 1999, pursuant to section 1371.35(j) of the Health and Safety Code:

   (a) A claim or portion thereof, is reasonably contested if the plan has not received the completed claim pursuant to Section 1371.35(c) of the Health and Safety Code, and
   (b) Any state-designated data requirements included in statutes or regulations.

2. For institutional providers:

   (a) Completed UB 04 data set or its successor format adopted by the National Uniform Billing committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC;
   (b) Entities stated as mandatory by NUBC and required by federal statute and regulations; and
   (c) Any state-designated data requirements included in statues or regulations.

3. For physicians and other professional providers:

   (a) Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim committee (NUCC) submitted on the designated paper or electronic format;
   (b) Current Procedural Terminology (CPT) codes and modifiers and International Classification of diseases (ICD-9/ICD-10 CM) codes;
   (c) Entries stated as mandatory by NUCC and required by federal statute and regulations; and
   (d) Any state-designated data requirements included in statutes or regulations.

Adriana Regalado

Vice-President of Claims - 1/2021

4. For pharmacists;

   (a) Universal claim form and data set approved by the National Council on Prescription Drug Programs; and
   (b) Any state-designated data requirements included in statutes or regulations.

5. For providers not otherwise specified in this policy or the applicable sections of the Code of California Regulations:

   (a) A properly completed paper or electronic billing instrument submitted in accordance with the contracted IPA/Medi-Cal Group's reasonable specifications; and
   (b) Any state-designated data requirements included in statutes or regulations.

Date of Contest, Date of Denial, or Date of Notice: The date of postmark or electronic mark accurately setting forth the date on which the contest, denial, or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.

Date of Payment: The date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, when auditing claims payment compliance, the date the check is printed and the date the check is presented for payment may be considered. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code Section 641.

Date of Receipt: The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

For claims received for payment, HSMSO ensures compliance with Medicare Managed Care Manual Chapter 1, Section 80.2.1, which states the receipt date of a claim is the date the contractor (payor) receives the claim (provided the filing is in a format and contains data sufficiently complete so that the filing qualifies as a claim). The receipt date is used to: determine if the claim was timely filed (see §70.3), determine the "payment floor" for the claim (see §80.2.1.2), determine the "payment ceiling" on the claim (see §80.2.1.1) and, when applicable, to calculate interest payment due for a clean claim that is not timely processed, and to report to CMS statistical data on claims, such as in workload reports. A paper claim that is received by 5:00 p.m. on a business day, or by closing time if the contractor routinely ends its public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that

date, even if the contractor does not open the envelope until a later date. A paper claim that is received after 5:00 p.m., or after the contractor's routine close of business between 4:00 p.m. and 5:00 p.m., is considered as received on the next business day. A paper claim is considered as received if it is delivered to the contractor's place of business by the U.S. Postal Service, picked up from a P.O. box, or is otherwise delivered to the contractor's place of business by its routine close of business time. If the contractor uses a P.O. box for receipt of mailed claims, it must have its mail picked up from its box at least once per business day unless precluded on a particular day by the emergency closing of its place of business or that of its postal box site. As electronic claim tapes and diskettes that may be submitted by providers are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt rule also applies to establish the date of receipt of claims submitted on such manually delivered tapes and diskettes. Electronic claims transmitted directly to a contractor, or to a clearinghouse with which the contractor contracts as its representative for the receipt of its claims, by 5:00 p.m. in the contractor's time zone, or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m., must likewise be considered as received on that day even if the contractor does not upload or process the data until a later date.

Date of Service: For purposes of evaluating claims submission and payment requirements:

1. For outpatient services and all emergency services and care: the date upon which the provider delivered separately billable health care services to the enrollee;

2. For inpatient services: the date upon which the member was discharged from the inpatient facility. However, HSMSO shall accept separately billable claims for inpatient services on at least a bi-weekly basis.

Demonstrable and Unjust Payment Pattern or Unfair Payment Pattern: Any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. The following practices, policies and procedures may constitute a basis for a finding that HSMSO, on behalf of the contracted IPA or IPA/Medi-Cal Group's capitated provider, has engaged in a demonstrable and unjust payment pattern.

1. The imposition of a Claims Filing Deadline inconsistent with this policy in three (3) or more claims over the course of any three (3) month period;

2. The failure to forward at least 95% of misdirected claims consistent with Section "Procedure B" of this policy over the course of any three (3) month period;

3. The failure to accept a late claim consistent with Section "Procedure A.2 at least 95% of the time for the affected claims over the course of any three (3) month period;

4. The failure to request reimbursement of an overpayment of a claim consistent with the provisions of this policy at least 95% of the time for the affected claims over the course of any three-month period;

Adriana Regalado

Vice-President of Claims - 1/2021

5. The failure to acknowledge the receipt of at least 95% of claims consistent with Section "Procedure C" of this policy over the course of any three-month period;

6. The failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with Section "Procedure E" of this policy at least 95% of the time for the affected claims over the course of any three-month period;

7. The inclusion of contract provisions in a provider contract that requires the provider to submit medical records that are not Reasonably Relevant Information, for the adjudication of a claim on three (3) or more occasions over the course of any three month period;

8. The failure to establish, upon written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to HSMSO on behalf of the contracted IPA or IPA/Medi-Cal Group's capitated provider by all providers over any 12-month period was Information Necessary to Determine Payer Liability for those claims. The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;

9. The failure to establish, upon written request, requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to HSMSO or for emergency room service and care over any 12-month period was Reasonably Necessary To Determine Payer Liability for those claims. The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where HSMSO demonstrates reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices;

10. The failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period;

11. The failure to contest or deny a claim, or portion thereof, within the timeframes of this policy at least 95% of the time for the affected claims over the course of any three (3) month period;

12. The failure to provide the Information for Contracting Providers and the Fee Schedule and Other Required Information disclosures required in the Policy Section, paragraph nine of this policy to three (3) or more contracted providers over the course of any three (3) month period;

13. The failure to provide three (3) or more contracted providers the required notice for Modifications to the Information for Contracting Providers and to the Fee Schedule and

Adriana Regalado

Vice-President of Claims - 1/2021

Other Required Information consistent with the Policy Section, paragraph nine of this policy over the course of any three month period;

14. Requiring or allowing any provider to waive any protections or to assume any obligation of the plan inconsistent with this policy on three (3) or more occasions over the course of any three month period;

15. The failure to provide the required Notice to Provider of Dispute Resolution Mechanism(s) consistent with section 1300.71.38(b) of the Health and Safety Code at least 95% of the time for the affected claims over the course of any three- month period;

16. The imposition of a provider dispute filing deadline inconsistent with PR.1 Provider Complaint Policy in three (3) or more affected claims over the course of any three-month period;

17. The failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with PR.1 Provider Complaint Policy over the course of any three-month period;

18. The failure to comply with the Time Period for Resolution and Written Determination enumerated in PR.1 Provider Complaint Policy at least 95% of the time over the course of any three-month period; and

19. An attempt to rescind or modify an authorization for health care services after the provider renders service in good faith and pursuant to the authorization, inconsistent with section 1371.8 of the Health and Safety Code, on three (3) or more occasions over the course of any three-month period.

Evidence Code Section 641: Letter received in ordinary course of mail. A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail.

Information Necessary to Determine Payer Liability: The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, comply with any governmental information requirements.

Management Services Organization (MSO): Management Company for IPA/Medi-Cal Groups, specifically HealthSmart Management Services Organization (HSMSO)

OIG Excluded Providers
The Office of the Inspector General (OIG) maintains a sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. The MA organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to

employ, or contracting with individuals named on that list. The MA organizations should check the Office of the Inspector General (OIG) Web site at http://www.oig.hhs.gov/fraud/exclusions/list of excluded.html for the listing of excluded providers and entities. The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR 1001.1901.

Opt-Out Providers
If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. The MA organization must check this list on a regular basis.
(Source: 42 CFR 422.204(b)(4) and 42 CFR 422.220)

Reasonably Relevant Information: "The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent HSMSO, on behalf of the contracted IPA or IPA/Medi-Cal Group's capitated provider's liability, if any, to comply with any governmental information requirements.

Reconsideration - A party or, upon providing oral or written notice to the enrollee, a physician who is treating an enrollee and acting on the enrollee's behalf, may request a standard reconsideration by filing a written request with the Medicare health plan. Except in the case of an extension of the filing time frame, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination. If a request for reconsideration is filed beyond the 60 calendar day timeframe and good cause for late filing is not provided, the Medicare health plan will forward the request to the independent review entity for dismissal. **See Item E 12 below regarding HSMSO forwarding of appeal to applicable Health Plan.**

Reimbursement of a Provider Claim

1. For contracted providers with a written contract, the agreed upon contract rate;

2. For providers without a written contract and non-contracted providers for Commercial Members the payment of the reasonable and customary value for the health care service rendered based upon statistically credible information that is updated at least annually and takes into consideration:

    a. the provider's training, qualifications, and length of time in practice;
    b. the nature of the services provided;
    c. the fees usually charged by the provider;

d. prevailing provider rates charged in the general geographic area in which the services were rendered;
e. other aspects of the economics of the Medi-Cal provider's practice that are relevant; and
f. any unusual circumstances in the case

3. For providers without a written contract and non-contracted providers for Medi- Cal members services rendered are paid at prevailing Medi-Cal Rates.

4. Providers without a written contract and non-contracted providers for Medicare members are paid according to Medicare Guidelines at 100% of prevailing Medicare Rates and specific regulatory pricing calculations.

5. Services rendered to Medicare members are subject to the 2% Sequestration - reduction in federal payment

Working Days: Monday through Friday, excluding Federally recognized holidays.

PROCEDURE:

A. Claims Filing Deadlines

1. **COMMERCIAL LINE OF BUSINESS:** IPA shall not impose a deadline for the receipt of a claim that is less than ninety (90) days for contracted providers and one hundred and eighty (180) days for non-contracted providers after the Date of Service for Commercial claims.

2. **MEDI-CAL LINE OF BUSINESS:** IPA shall not impose a deadline for the receipt of a claim that is less than ninety (90) days for contracted providers. For non-contracted providers, claims that are not received within the six-month billing limit and do not meet any of the delay reasons set forth by Medi-Cal will be reimbursed at a reduced rate or will be denied as follows:

    - Claims received during the seventh through the ninth month after the month of service will be reimbursed at 75% of the payable amount.
    - Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50% of the payable amount
    - Claims received after the twelfth month following the month of service will be denied.

3. **MEDICARE LINE OF BUSINESS:** IPA shall not impose a deadline for the receipt of a claim that is less than ninety (90) days for contracted providers and three hundred sixty-five day (365) days for non-contracted providers after the Date of Service.

Adriana Regalado

Vice-President of Claims - 1/2021

4. Should HSMSO deny a claim because it was filed beyond the claim filing deadline, HSMSO shall, upon a provider's submission of a provider dispute and the demonstration of good cause for the delay, accept and adjudicate the claim.

B. Misdirected Claims

1. If a claim is sent to IPA and the health plan is responsible for adjudicating the claim the IPA shall forward the claim to the appropriate payor within ten (10) working Days after the receipt of the claim incorrectly sent to HSMSO on behalf of the contracted IPA/Medi-Cal Group. Note: for CalOptima the misdirected claim will be forwarded within 8 working days.

2. If a claim is sent to IPA and the health plan is responsible for adjudicating the claim the IPA shall forward the claim to the appropriate payor within ten (10) Calendar Days after the receipt of the claim incorrectly sent to HSMSO on behalf of the contracted IPA/Medi-Cal Group for Medicare Line of Business.

C. Acknowledgement of Claims

1. In the case of an electronic claim, identification and acknowledgement is provided within two (2) working days after the Date of Receipt of the claim by the office designated to receive the claims, or in the case of a paper claim, identification and acknowledgement is provided within fifteen (15) Working Days after the Date of Receipt of the claim by the IPA Claims Department.

2. If the provider submits a claim using a claims clearinghouse, HSMSO on behalf of the contracted IPA/Medi-Cal Group's identification and acknowledgement to the clearing house within the timeframes set forth in subparagraph (C1) of this section, whichever is applicable, shall constitute compliance with this section.

D. Complete Claims Processing

1. A Complete Claims can be processed as soon as it is received.

2. Complete claims are identified properly by the claims processor when received from the mailroom, already prepared for processing (i.e. date stamped, logged, and data entered or scanned).

3. All claims are noted with the date received, paper claims are date stamped the date the claim is received, and received dates are monitored to ensure timeliness compliance. In

accordance with Chapter 1 Section 80.2.1 Claims received by 5:00 pm (local time) must be considered as received on that date.

4. Complete claims are processed within a reasonable turn-around-time frame to meet the following criteria:

    a. Timeliness – Commercial and Medi-Cal

        i. Complete claims are processed within thirty (30) calendar days for Medi-Cal Program and within forty-five (45) working days for Commercial from the Date of Receipt.
        ii. For all lines of business, except for Medicare, if a complete claim is not reimbursed by delivery of payment to the providers address of record within timeframes specified in (3a), automatic payment of interest is included with the original payment or is due within 5 working days of the payment of the claim without the need for any reminder or request by the provider. **If interest on a claim is less than $2.00, the interest for that claim may be paid, along with interest on other such claims, within ten (10) calendar days of the close of the calendar month in which the original claim was paid.**
        iii. For all lines of business except Medicare, if an uncontested claim is not reimbursed by delivery of payment to the claimant's address of record within forty five (45) working days after receipt, interest shall accrue at a rate of 15% per Annum beginning with the first calendar day after the forty-five working-day period. The interest calculation is as follows:

            The $ amount paid for the claim * the # of days the claim is late * 0.000411.

            Note: Interest on late emergency room claims is paid at $15.00 or 15% per annum, whichever is greater.

    b. Timeliness – Medicare

        i. Complete claims are processed within, **thirty (30) calendar days** for Non-Contracted Medicare Providers and within **sixty (60) calendar days** for Contracted Medicare Providers, from the Date of Receipt.
        ii. If a complete claim is not reimbursed by delivery of payment to the providers address of record within timeframes specified in (3a), automatic payment of interest is included with the original payment or is due within 5 working Days of the payment of the claim without the need for any reminder or request by the provider. If interest on a claim is less than $2.00, the interest for that claim may be paid, along with interest on other such claims, within 10 calendar days of the close of the calendar month in which the original claim was paid.
        iii. Interest is required to be paid for clean claims not paid within 30 days

Adriana Regalado

Vice-President of Claims - 1/2021

after the day of receipt of a claim.

- Interest is calculated beginning calendar day 31 for non-contracted providers and the interest rate is the applicable rate at the time of payment.
- Interest accrues until and including the day of late payment. Interest must be paid on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on October 1, 2017, must have been paid before the end of business on October 31, 2017.
- Interest is not paid on:
  - Claims requiring external investigation or development by the payor;
  - Claims on which no payment is due;
  - Full denials
  - Claims for which the provider is receiving PIP; or
  - Home Health Prospective Payment System (HH PPS) Requests for Anticipated Payment (RAPs).

c. Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment.

The correct interest rate for the payment period is accessible on the Treasury Department web page: *http://www.publicdebt.treas.gov/opd/opdprmt2.htm*

d. Accuracy – Covered services are paid in conformance with the standard allowances set by the health plan and/or contractual rates with providers.

E. Denying, Adjusting, or Contesting (Pending) a Claim

1. HSMSO can contest or deny a claim, or portion thereof, by notifying the provider, in writing.

2. Claims that are not Complete Claims are identified by the claims processor when received from the mailroom, already prepared for processing (i.e. date stamped, logged, and data entered or scanned).

3. In the event HSMSO requests reasonably Relevant Information from a provider in

addition to information that the provider submits with a claim, HSMSO shall provide a clear, accurate, and written explanation of the necessity for the request.

a. A pended report indicating those claims that are pended shall be generated daily by the Claims Department Lead.

i. For Non-Contracted Medicare Providers, claims pended longer than fifty-five (55) calendar days, the claims processor shall generate a letter.
ii. For Contracted Medicare Providers, claims pended longer than fifty-five (55) calendar days, the claims processor shall generate a letter.
iii. For Non-Contracted Medi-Cal and Commercial Providers, pend the claim and follow up with to provider for the information.

b. When the requested information is received:

i. If the claim is open (still unpaid/not denied for non-receipt), the claims processor shall finalize the claim with the requested information. If the claim is nearing non-compliance, the claims processor shall expedite its processing, including utilizing the assistance of the Claims Supervisor in order to resolve the claim within thirty (30) calendar days for Medi-Cal Program and forty- five (45) working days for Commercial Line of Business.

4. Non-Contracted Medi-Cal and Commercial providers may also be denied immediately. A Denial Letter is issued immediately, informing the member of their appeal rights.

5. If HSMSO subsequently denies the claim based on the provider's failure to provide the requested medical records or other information, any dispute arising from the denial of such claim shall be handled as a provider dispute.

6. Denied, adjusted or contested claims include information on filing a provider dispute, including procedures for obtaining provider dispute forms and the mailing address for submission of the dispute.

7. HSMSO shall issue a Notice of Denial of Payment (NDP) letter, within 30 days of receipt for any Medicare, Medi-Cal and ERISA clean claim. The NDP letter is sent to the member. The written denial must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard reconsideration and describe the appeal process.

8. NDP letters shall be sent within 60 days of receipt for any non-clean claim. The NDP letter is sent to the member. The written denial must clearly state the service denied and



the specific denial reason. The notice must also inform the enrollee of his or her right to a standard reconsideration and describe the appeal process.

9. A request for Information Necessary to Determine Payer Liability from a third party shall not extend the time of reimbursement or the time for contesting or denying claims. Incomplete claims and claims for which Information Necessary to Determine Payer Liability has been requested, which are held or pended awaiting receipt of additional information shall be either contested or denied in writing within the timeframes set forth in this section. The denial or contest shall identify the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability.

10. Whenever a denial is made, the currently approved notice or letter format respective to the applicable Health Plan shall be used, including approved denial reasons/codes.

11. In the event of a denial of a request for payment from a non-contracted provider, HSMSO shall notify the provider of the specific denial reason(s) and provide a description of the appeals process.

12. A non-contracted provider may file an appeal only if a Waiver of Liability statement has been completed. By signing the waiver, the non-contracted provider waives any rights to balance billing the member for covered services.

13. Cal Optima; Under no circumstances shall a claim be denied for the second time as a consequence of responding to a request for reconsideration ("Appeal") from an Enrollee; instead, HSMSO, on behalf of the contracted Group must direct the Enrollee to submit the request directly to CalOptima as appropriate.

14. Per HSMSO policy, a Member (including his or her authorized representative) may to appeal denials within 60 days from the date of the original denial. Upon receipt of the appeal, HSMSO shall, within 48 hour, forward the appeal to the applicable Health Plan.

15. Easy Choice – All Member appeals must be submitted to Easy Choice for appropriate appeal processing within 48 hours of receipt.

F. Reimbursement of the Overpayment of Claims

1. If HSMSO determines that it has overpaid a claim, within three-hundred and sixty- five (365) days of such payment, it shall notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service and include a clear explanation of the basis upon which HSMSO believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. If the provider contests HSMSO's notice of reimbursement of the overpayment of a



claim, the provider, within thirty (30) Working Days of the receipt of the notice of overpayment of a claim, shall send written notice to HSMSO stating the basis upon which the provider believes that the claim was not over paid. HSMSO shall receive and process the contested notice of overpayment of a claim as a provider dispute pursuant to HSMSO's Provider Complaint Policy.

3. If the provider does not contest HSMOS' notice of reimbursement of the overpayment of a claim, the provider shall reimburse HSMSO within thirty (30) Working Days of the receipt by the provider of the notice of overpayment of a claim.

4. HSMSO may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse HSMOS' within the timeframe above and (ii) the provider has entered into a written contract with specifically authorizing HSMSO on behalf of the contracted IPA to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset against a provider's current claim or claims pursuant to this section, HSMSO shall provide the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

G. Mailings and Notifications – Per Chapter 3, Section 50.16 of the Medicare Managed Care Manual

1. All mailings to Medicare beneficiaries must be categorized as an advertising piece, plan information, or health and wellness mailing.

2. Claim correspondence is categorized as plan information and the following statement must appear on the envelope or the mailing itself if no envelope is used:

    a. Important Plan Information

3. This statement cannot be altered and no additional statements can be used. Statement must be written in Times New Roman, 12 pt font, located on the front of the envelope or mailing itself and must not be part of the return address.

H. Standardization of Plan Name Type - Per the Medicare Managed Care Manual, Chapter 3, Section 40.13 any materials sent to Medicare beneficiaries (using model or non-model language) must include the plan type (HMO or PPO, etc.) in the plan name on the front page or at the beginning of the document. Logos that include the plan name must also include the plan type.

1. HSMSO shall ensure that all materials sent to Medicare beneficiaries includes the Plan type in the Plan name on the front page or at the beginning of the document.

2. HSMSO shall ensure that any use of Plan logos where the Plan name is used, the Plan



name shall also include the Plan type.

I. Provider Training

1. At the time of initial contracting, and on an annual basis, and upon a contracted providers' written request, HSMSO in coordination with the contracted IPA shall provide the following information in a paper or electronic format, which may include a website containing this information, or another mutually agreeable accessible format:

    a. Directions for claims inquiries and filing information;
    b. The identity of the office responsible for receiving and resolving provider disputes;
    c. Directions for provider dispute inquiries and filing information;
    d. Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single provider dispute that includes a numbering scheme identifying each dispute contained in the bundled cases.
    e. Complete fee schedule for the contracting provider;
    f. Detailed payment policies and procedures and rules and non-standard coding methodologies used to adjudicate claims.
    g. HSMSO, in coordination with the contracted IPA/Medical Group, shall provide a minimum of forty-five (45) days prior written notice before instituting any changes, amendments, or modification in the disclosures pursuant to the preceding information.

J. Monitoring Claims for Compliance

1. Claims Department Lead shall monitor the paid, denied and pended claims reports daily to ensure that claims are correctly processed and coded, and that the claims meet the timeliness requirements.

2. Claims Manager shall ensure that timeliness reports are completed weekly and shall develop specific action plans to address any deficiencies noted in these reports.

3. Claims Supervisor and Claims Department Lead shall provide feedback to the Claims Manager on any deficiencies noted in audits conducted by the contracted IPA/Medi-Cal Group.

4. Action plans related to individual examiners or to the unit as a whole shall be documented and maintained by the Claims Manager for periodic review by the AVP of Client Services.

5. Claims shall monitor the information generated from the Credentialing Department on a monthly basis regarding providers who have been identified from the Medicare Op-Out

Adriana Regalado

Vice-President of Claims - 1/2021

Report and those identified on the OIG found guilty of fraudulent billing, misrepresentation of credentials, etc.

6. The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR 1001.1901

7. HSMSO shall ensure compliance with Chapter 6, Section 60.2 of the Medicare Managed Care Manual, and shall maintain policies and procedures to ensure non- emergent claims have been denied from providers that have opted out of Medicare

    a. In the event the provider has opted out of Medicare and has submitted a claim for emergent services, the claim may be paid.
    b. If however, the claim from a provider who is opted out of Medicare is for non-emergent services the claim must be denied.

K. Report to Health Plans

1. HSMSO shall submit required claims performance reports within fifteen (15) days after the close of each reporting period in the format required by the health plan.

L. Record Maintenance

1. Claims File and Retrieval System

    a. HSMSO shall maintain a claims retrieval system that can identify and acknowledge the date of receipt, whether or not it was a Clean Claim, the action taken on all provider claims (i.e. paid, denied, pended) and the date the action was taken, in the same manner as the claim was submitted.

2. Retention

    a. All patient Medi-Cal records and claim information data shall be maintained by HSMSO for a period of at least ten (10) years and shall not be removed or transferred from its office except in accordance with applicable law.

REFERENCES:
California Health and Safety Code Sections 1371, 1371.35 and 1371.38
California Code of Regulations (CCR) Title 28 Rules 1300.71 and 1300.71.38 42 CFR 422.2272(b); 423.2272(b); 422.2268 (q); 423.2268 (q)
Medicare Managed Care Manual, Chapters 1, 3, 6 and 13

Adriana Regalado
Vice-President of Claims - 1/2021

SUBJECT: Coordination of Benefits and Dual Coverage **Policy #:** CLM020

DEPARTMENT: Claims

Effective Date: January 2007
Last Revision: January 2008; November 2013, March 2015, April 2015
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021, January 2023

SCOPE:
This policy applies to all Lines of Business.

PURPOSE:
To adjudicate claims accurately and accordingly as relates to primary or secondary payer status. Coordination of benefits occurs when a member is covered under a Medicare (or MA Plan) and has other coverage. For example, a member may have Medi-Cal coverage with a contracted health plan and have original Medicare, or a member may have two health plans, one as a subscriber and the second as a dependent.

To ensure claims are adjudicated in accordance with Medicare Secondary Payor (MSP) rules.

To accurately adjudicate claims under the correct line of business when member has dual coverage through the same IPA managed by HealthSmart Management Services Organization (HSMSO).

To be able to identify when there is a possibility of Third Party Liability, which could result in recovery of monies for the member's medical group.

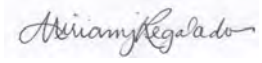
POLICY:
It is the policy of HSMSO to ensure claims are adjudicated, including those that dictate Coordination of Benefits (COB) for Medicare enrollees. COB is applied in accordance with state and federal law governing COB, including the Order of Determination of payment.

HSMSO shall identify and report to CalOptima any enrollee reports of other employer health coverage or other private or public health insurance. HSMSO shall identify and report to CalOptima any EOP/EOMB received with other coverage payment.

Reports are run based on possible TPL for Medicare and Commercial Lines of Business. The report criteria are ICD codes beginning with E], 8] or 9] or ICD 10 codes beginning with T or S, for the month prior.

Once the report is generated, the claims are sorted by member and reviewed.

Any patient profile that does not constitute a possible TPL is removed from the report.



Vice-President of Claims - 1/2021

All remainder patients will have a Third Party Liability Questionnaire generated and mailed to the patient ***(See Attached Questionnaire)***.

PROCEDURE:

A. Dual Coverage

1. When a claim is received for a member with dual accounts, the following rule is applied:

2. HSMSO will processes the claims for members covered under the Medicare account as primary and process any remainder liability under the Medi- Cal account as secondary, unless under Medicare As Secondary Payor Rules it is determined that Medicare is secondary.

3. If it is identified that Medicare is the secondary Payer, the Medi-Cal account will be processed as primary.

B. Coordination of Benefits

1. There are various methods in which a member can be identified as potentially having other coverage or has other coverage:

    a. Health Plan Eligibility Files
    b. EOP attached to a claim
    c. ICD 9 codes beginning with E, 8, or 9, or ICD 10 codes beginning with T or S,
    d. Occurrence Codes 01,02,03,04,05,06,18,19,33
    e. Condition Codes 02,04,05,06,07,08,09,10,11,28,77
    f. A member who is 65 years and older
    g. ESRD recipients

2. The following is a determination of when Medicare is considered primary or secondary when it has been identified that the member has other coverage.

    a. When a claim is received for a Medicare recipient with Medi-Cal coverage
        i. Medicare is the primary
        NOTE: Medi-Cal is always payor of last resort.

    b. When a claim is received for a Medicare recipient with workers' compensation
        i. Medicare is secondary

c. When a claim is received for a Medicare recipient with other insurance liability
    i. **Medicare MAY be secondary**

d. *Individual is age 65 or older*, is covered by a GHP through current employment or spouse's current employment AND *the employer has less than 20 employees:*
Medicare pays Primary, GHP pays secondary

e. When a claim is received for a Medicare member who is 65 years or older, AND who is covered by a Group Health Plan (GHP) because of either: Current employment
OR
Current employment of a
spouse AND
The employer employs 20 or more employees
    i. **Medicare is secondary**

f. When a claim is received for a Medicare member who is disabled, AND who is covered by a Large Group Health Plan (LGHP) because of either:
Current employment
OR
A family member's current
employment AND
The employer employs 100 or more employees
    i. **Medicare is secondary**

g. When a claim is received for a Medicare member with a Diagnosis of End Stage Renal Disease (ESRD)* with other Insurance liability.
    i. **Months 0-30 – Medicare is secondary**
    ii. **Over 30 months – Medicare is primary**
This provision applies regardless of the number of employees and the enrollee's employment status.

h. When a claim is received for a Medicare member with:
An accident or trauma diagnosis that may begin with E, 8, or 9,
OR Occurrence Codes 01, 02, 03, 04, 05, 06, 18, 19, 33, OR
Condition Codes 02, 04, 05, 06, 07, 08, 09, 10, 11, 28, 77
    i. **Medicare is primary****
****Medicare Advantage Organizations cannot withhold payment as primary even if there is an expectation of reimbursement from another insurer.***

3. When it has been identified that Medicare is secondary, Medicare will pay only when the information on the primary payer is attached to the claim. Each

Adriana Regalado
Vice-President of Claims - 1/2021

Claims Examiner is responsible for researching and attaining all information needed to process claims in conjunction with COB.

4. When a provider is contracted, pay benefits for services that are authorized in coordination with the primary insurance carrier only up to the contracted rate.

5. When a provider is not contracted, and found not to accept a discounted fee, coordination is up to 100% of Medicare or Medi-Cal allowable rates.

6. When a primary deductible has not been met, services are paid in full in accordance with a provider's contract.

7. When a COB claim is ready for processing and it is found that the COB information was not previously known, a copy of the EOP is forwarded to the Customer Services Department to flag the account for future payments and previous claims are researched for potential recovery.

8. Referral requirements are not followed when a member is secondary with the IPA/Medical and the primary insurance allowed the charge.

C. Medicare Secondary Payer (MSP) Claims Investigation

1. When it has been identified through one of the methods above, that the member may have other coverage, and the provider did not submit an explanation of benefits (EOP) for the other carrier, a Medicare Secondary Payer (MSP) claims investigation occurs.

2. A questionnaire is sent to collect information on the existence of other insurance that may be primary to Medicare. This questionnaire may be sent to the beneficiary, provider, attorney, or insurer. Once the questionnaire is received the TPL Coordinator determines if Medicare is primary or secondary.

3. If Medicare is primary, process for payment and the member file will be documented that there is no other coverage for the timeframe when the services occurred.

4. If Medicare is secondary due to a State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self - insured plan, HSMSO has a contractual obligation to pay for Medi-Cal services provided to the covered/injured person.

5. Referral requirements are not followed when a member is secondary with the IPA/Medical group and the primary insurance allowed the charge.

D. Recovery Rights

1. It is common for insurance companies to settle claims without admitting liability. Therefore, any payment by a liability insurer, except payments under a no-fault clause in a non-automobile policy, constitutes a liability insurance payment whether there has been a determination of liability. In addition, regardless of how amounts may be designated in a liability award or settlement, e.g., loss of consortium, special damages or pain and suffering, HSMSO is entitled to be reimbursed for its payments from the proceeds of the award or settlement.

2. HSMSO has a statutory direct right of recovery from the liability insurance as well as any entity that has received payment directly or indirectly from the proceeds of a liability insurance payment. HSMSO's recovery rights take precedence over the claims of any other party. The right to recover is superior to other entities due to Medicare's direct right of recovery is explicitly prescribed in Federal Law and other entities' recovery rights are based on either State law or subrogation rights.

3. If HSMSO exercises its subrogation rights, HSMSO is a claimant against the responsible party and the liability insurer to the extent that HSMSO has made payments to or on the behalf of the beneficiary for services related to claims against the alleged tortfeasor (and the alleged tortfeasor's liability insurance).

4. HSMSO can be a party to any claim by a beneficiary or other entity against an alleged tortfeasor (a person who commits a tort (civil wrong), either intentionally or through negligence) and/or his/her liability insurance and can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to HSMSO.

E. Cal MediConnect COB Requirements

1. Coordination of Benefits means the process of utilizing TPL resources to ensure that Medi-Cal is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or the method of post- payment recovery of the of services, if the coverage is identified retroactively.

2. DHCS shall refer to CalOptima the Enrollee's name and pertinent information where DHCS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist. CalOptima will provide this report

to HSMSO. HSMSO shall identify and notify CalOptima and the DHCS's TPL and Recovery Division of all instances or cases in which HSMSO believes an action by the Enrollee involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Enrollee of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, WIC. Contractor shall make no claim for recovery of the value of Covered Services rendered to an Enrollee in such cases or instances and such case or instance shall be referred to state's TPL Branch within ten (10) calendar days of discovery.

3. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an Enrollee, HSMSO shall deliver the requested information within thirty (30) calendar days of the request. Service information includes First Tier, Downstream, or Related Entity and out of plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to First Tier, Downstream, or Related Entity providers or out of plan providers for similar services, whichever is applicable under WIC Section 14124.90(c)(2).

4. HSMSO will designate a TPL Benefit Coordinator who shall serve as a contact person for benefit coordination issues, including those related to CalOptima.

5. Health Smart MSO designates one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

F. Cal Optima Requirements

1. HSMSO, on behalf of the contracting IPA will identify and report an instance or case in which it believes an action by a Medi-Cal Member involving casualty insurance, tort, or Worker's Compensation liability of a third party could result in a Member's recovery of funds to which the Department of Health Care Services (DHCS) has lien rights, upon identification.

2. HSMSO will make no claim for recovery of the value of covered services rendered to the Medi-Cal Member in the instance or case where an action by a Member involving casualty insurance, tort, or Workers' Compensation liability of a third party could result in a Medi-Cal Member's recovery of funds to which DHCS has lien rights.

3. HSMSO will provide service information or copies of paid invoices of claims for Covered Services to a Medi-Cal Member upon CalOptima's or DHCS' request.

4. If HSMSO, on behalf of the contracted IPA receives a request from an attorney,

Adriana Regalado

Vice-President of Claims - 1/2021

insurer, or Member for a copy of a bill, HSMSO shall refer the request to CalOptima's TPL Branch with the information required under CalOptima's applicable policy.

5. On a monthly basis, HSMSO will submit a report to CalOptima which lists the members who have potential TPL either based on the authorization notes, or with an ICD beginning with "E", or or ICD 10 codes beginning with T or S, of claims processed in the month prior.

6. The file will contain the following information:
    a. Claim Number
    b. Member Name
    c. Medi-Cal Beneficiary identification number
    d. Member's Date of Birth
    e. Provider's status (contracted or non-contracted)
    f. Vendor (payment issued to)
    g. Provider (physician who provided the service(s))
    h. Date(s) of service
    i. WCAB number (if applicable and known)
    j. Diagnosis Code(s)
    k. Procedure Code(s)
    l. Amount Billed for each procedure
    m. Amount IPA paid for each procedure
    n. Date Payment was issued
    o. Denial Reason or Remarks relating to the service

7. If a request for TPL information is requested either from CalOptima or DHCS, HSMSO will forward the requested information within five (5) calendar days of receipt of the request.

REFERENCES:
Medicare Managed Care Manual Chapter 4
Medicare Secondary Payer Chapter 2 and 7
42 CFR 422.106



Vice-President of Claims - 1/2021

SUBJECT: Denials for Commercial Claims **Policy #:** CLM029
DEPARTMENT: Claims

Effective Date: January 2006
Last Revision: July 2006; January 2011, April 2015
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021, January 2023

SCOPE:
This policy applies to Commercial Line of Business

PURPOSE:
To provide a mechanism to ensure claims denied as the member's responsibility are denied appropriately, timely and clearly communicated to enrollees and providers.

POLICY:
Pursuant to the CA Health and Safety Code 1371.35 (a), it is the policy of HealthSmart Management Services Organization (HSMSO) to deny a claim, or portion thereof, by notifying the provider and/or the member, in writing, that the claim is denied within 45 business days after receipt of the claim by HSMSO.

The Claims examiner is to utilize the Commercial Claims Denial Reason Guide provided by the Industry Collaborative Efforts (ICE) committee when determining if a letter is to be generated to the member. These would be for services provided in which the member has a financial liability for costs incurred.

PROCEDURE:

1. All claim denials determined to be the responsibility of the member will be reviewed by the examiner to determine the appropriateness of the denial.

2. A denial letter is generated in the eHealthcare system by clicking on the "Demand Denial Letter" icon in the Claims Module.

3. Once in the "Demand Claim Denial Letter" window, the examiner will select the appropriate denial reason in the drop down menu.

4. The ICE Claims Commercial Denial Reason Guide is utilized by the examiner for the appropriate denial language to use for the specific denial reason. The guide will also specify if the letter will be sent to the provider only, member only, or both provider **and** member.
5. Once the complete language is copied into the window, the examiner will click on the "Get Letter" icon.

6. The letter is generated and will contain following information:
    - Date letter is generated



Vice-President of Claims - 1/2021

- Member ID#
- Member Address
- Date of Service
- Service Codes
- Billed Amount
- Provider Information
- Specific Rationale for Decision
- Member's Appeal Rights
- Address where to send the Appeal

7. The Denial Letter is printed and put in an envelope stamped **"Important Health Plan Information"**.
8. The letter is postmarked and mailed to the provider and/or member.
9. Member denials for Commercial members, with the exception of ERISA members must be issued within 45 working days from the date of claim receipt. Member denials for ERISA members must be issued within 30 calendar days from the date of claim receipt.

*Please see **Attachment CLM029** ICE Commercial Denial Reason Guide*

Adriana Regalado

Vice-President of Claims - 1/2021

SUBJECT: EOPs and Denial Codes/Reasons **Policy #:** CLM030
DEPARTMENT: Claims

Effective Date: January 2007
Last Revision: July 2008; July 2009; January 2010; January 2011; January 2012; January 2013
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021, January 2023

SCOPE:
This policy applies to All Lines of Business.

PURPOSE:
To be able to provide a clear written explanation of the payment, denial, adjustment, or reason for contesting of the claim.

POLICY:
It is the policy of HealthSmart Management Services Organization (HSMSO) to ensure that guidelines are established for use of adjustment codes to generate claims payment explanations.

PROCEDURE:
A. When claims are processed outside of the normal Claims Processing guidelines, or if the provider is non-contracted, the Claims Examiner must utilize the Claim Adjustment Codes in order to provide a clear explanation of how the claim was processed. External EOP Comments may also be utilized in order to expand on the Claim Adjustment/Remark Code chosen.

B. Internal Comments
This field is a free form text area in which the Claims Examiner may type additional information for the viewing of HSMSO. employees only. This field is utilized when additional information may be needed in order to better communicate internally.

C. External EOP Comments
This field is a free form text area in which the Claims Examiner may type additional information for the viewing of HSMSOemployees as well as it is documented in the NOTE section of the EOP for the Provider. This field is utilized when the Claims Examiner is wanting to provide additional information to the Provider in order for him/her to better understand the method if payment and/or the reason for denial/contesting of the claim.

D. Adjustment Codes
This field is a standard field, which allows the claims examiner to choose a standardized explanation. This standardized Code and Reason is automatically printed on the EOP that is mailed to the provider. This field is utilized when the Claims Examiner is wanting to provide information to the Provider in order for him/her to better understand the method if payment and/or the reason for denial/contesting of the claim.

Adriana Regalado
Vice-President of Claims - 1/2021

(see attached Claim Adjustment/Remark Codes)



Vice-President of Claims - 1/2021

SUBJECT: Denials for Medicare - Integrated Denial Notice (IDN) **Policy #:** CLM031

DEPARTMENT: Claims

Effective Date: January 2007
Last Revision: January 2008; November 2011; October 14, 2012; January 2013, April 2015
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021, January 2023

SCOPE:
This policy applies to Medicare Lines of Business.

PURPOSE:
To identify and provide an Integrated Denial Notice (IDN) to an enrollee when it is decided that the payment will be denied for medical services already received.

POLICY:
For compliance purposes an Integrated Denial Notice (IDN) is required when all of the following criteria is met:

1. Is a post-service financial claim
2. One or more services will not be paid
3. Payment is the responsibility of the member
4. The member must have liability

A document is created notifying a patient that an adverse coverage decision has been made as a result of adjudication of a provider claim for reimbursement. It identifies the billing provider, the services, the financial liability, the deciding organization, the reason for the decision, the appeal process, and where to direct written or verbal appeals or to request additional information and the time limit to do so.

PROCEDURE:

1. All claim denials determined to be the responsibility of the member will be reviewed by the examiner to determine the appropriateness of the denial.
2. An IDN is generated in the eHealthcare system by clicking on the "Demand Denial Letter" icon in the Claims Module.
4. Once in the "Demand Claim Denial Letter" window, the examiner will select the appropriate denial reason in the drop down menu.
5. The ICE Claims Medicare Advantage Denial Reason Guide is utilized by the examiner for the appropriate denial language to use for the specific denial reason. The guide will also specify if the letter will be sent to the provider only, member only, or both provider **and** member.
6. Once the complete language is copied into the window, the examiner will click on the "Get Letter" icon.
7. The letter is generated and will contain following information:



Vice-President of Claims - 1/2021

- Date letter is generated
- Member ID#
- Member Address
- Date of Service
- Service Codes
- Billed Amount
- Provider Information
- Specific Rationale for Decision
- Member's Appeal Rights
- Address where to send the Appeal

8. The Denial Letter is printed and put in an envelope stamped **"Important Health Plan Information"**.

9. The letter is postmarked and mailed to the provider and/or member.

10. Under Medicare regulations, a claim with incomplete data, including proper diagnosis coding required by CMS for submission for risk adjustment, is not a clean claim. Accordingly, we have up to 60 calendar days to work with non-contracted providers by asking them to provide complete claims data so that a proper evaluation of the claim can occur. Typically two requests should be made to the provider for complete claims data. If a complete claim is not received prior to day 60, the claim can be denied as an incomplete claim.

The following attachments are to be utilized when creating an Integrated Denial Notice:
Attachment A – Template for Integrated Denial Notice
Attachment B – ICE Claims Medicare Advantage Denial Reasons Guide

Adriana Regalado
Vice-President of Claims - 1/2021

SUBJECT: Provider Disputes Commercial and Medi-Cal **Policy #:** CLM040
DEPARTMENT: Claims

Effective Date: January 2006
Last Revision: July 2007; January 2011; December 2012
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021, January 2023

SCOPE:
This policy applies to Medi-Cal, Commercial and Cal Mediconnect Lines of Business.

PURPOSE:
To identify and process claims according to PDR regulations.

POLICY:
It is the policy of HealthSmart MSO (HSMSO) to ensure all PDRs are processed in accordance with applicable state and federal regulations.

PROCEDURE:
1. Claims which are submitted as a Provider Dispute will be processed according to PDR timeframes.

Provider Dispute Resolution Mechanism
Turnaround Time Frame

Description	Turnaround Time Frame
Deadline for Receipt of Provider Dispute	
For a dispute related to an individual claim, billing dispute or contractual dispute	Cannot impose a deadline of less than 365 days after the most recent action or, in the case of inaction, 365 days after time for contesting or denying claim has expired.
For a dispute related to a demonstrable and unfair payment pattern by the plan or the plan's capitated provider.	Cannot impose a deadline of less than 365 days after the most recent action or, in the case of inaction, 365 days after time for contesting or denying claim has expired.
Submission of Amended Provider Dispute	
Amended Provider Dispute	A provider may submit within 30 working days of the date of receipt of a returned provider dispute for purposes of requesting missing information.



Vice-President of Claims - 1/2021

Time Period for Acknowledgement	
Electronic Provider Dispute	Provided within 2 working days of the date of receipt of the electronic provider dispute
Paper Provider Dispute	Provided within 15 working dates of the date of receipt of the paper provider dispute
Time Period for Resolution and Written Determination	
Description	**Turnaround Time Frame**
Resolution and issuance of written determination for each provider dispute or amended provider dispute.	Resolution and a written determination must be completed within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. There will not be more than a 5 day lag from the written resolution to the EOP date.
Right of the Provider to Request a De Novo Review	
Any provider that submits a claim dispute to the plan's capitated provider's dispute resolution mechanism(s) involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the plan's dispute resolution process.	A provider has the right to submit an appeal for a de novo review and resolution to the Plan for a period of 60 working days from the capitated provider's Date of Determination.
Past Due Payments and Interest and Penalties	
Retention includes copies of provider disputes and determinations, including all notes, documents and other information used to reach decision.	Payment is due within 5 working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" of the complete claim.
Time Period for Provider Dispute Document Retention	

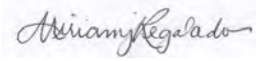
Adriana Regalado

Vice-President of Claims - 1/2021

Retention includes copies of provider disputes and determinations, including all notes, documents and other information used to reach decision.	Documents shall be retained for at least 5 years.
Submission of Required Reports	
Description	**Turnaround Time Frame**
"Annual Plan Claims Payment and Dispute Resolution Mechanism Report" shall include information disclosing the claims payment compliance status of the plan and each of its claims processing organizations and capitated providers.	The plan shall submit Annual Plan Claims Payment and Dispute Resolution Mechanism Report in electronic format to the DMHC no more than 15 days after the closure of the calendar year.
A Quarterly Claims Payment Performance Report ("Quarterly Claims Report") shall include a tabulated record of each provider dispute received.	The report shall be submitted to the plan within 30 days of the close of each calendar quarter.
Demonstrable and Unjust Payment Pattern	
The plan may submit a written response documenting that their practice, policy or procedure was a necessary and reasonable claims settlement practice and consistent with the requirements.	The plan may submit a written response within 30 days of receipt of notice that the DMHC is investigating whether the plan's or the plan's capitated provider's practice, policy or procedure constitutes a demonstrable and unjust payment pattern.

The following are definitions for what constitutes a PDR:

Dispute Resolution Mechanism Complete Definitions Including corresponding section of 1300.71.38, California Code of Regulations (CCR) title 28	
Term	**Definition**



Vice-President of Claims - 1/2021

Contracted Provider Dispute 1300.71.38 (a) Definitions (1)	A contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim.
Non-Contracted Provider Dispute 1300.71.38 (a) Definitions (2)	A non-contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim
Date of Receipt 1300.71.38 (a) Definitions (3)	The working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's or the plan's capitated provider's designated dispute resolution office or post office box. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.
Date of Determination 1300.71.38 (a) Definitions (4)	The date of postmark or electronic mark on the written provider dispute determination or amended provider dispute determination that is delivered, by physical or electronic means, to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Department may consider, when auditing the plan's or the plan's capitated provider's provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and date the check is presented for payment. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.
Plan 1300.71.38 (a) Definitions (5)	For the purposes of this section means a licensed health care service plan and its contracted claims processing organization(s).

Adriana Regalado

Vice-President of Claims - 1/2021

Notice to Provider of Dispute Resolution Mechanism(s) 1300.71.38 (a) Definitions (5)(b)	Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address, for filing a provider dispute.

2. When a claim is identified as a Provider Dispute, the claim is entered into the processing system and an acknowledgment letter is generated. A new claim number is generated by the system identifying the claim as a PDR, and linked to the original claim.

3. The claim is manually entered into a PDR log based on the member's assigned Medical Group/IPA. The information entered is:
    a. HealthPlan
    b. Claim Number
    c. Member Name
    d. Provider of service
    e. Contracted vs Non-Contracted
    f. Type of service
    g. Date of Service
    h. Received Date
    i. Acknowledgement Date
    j. Appeal Review Date
    k. Expected Reimbursement
    l. Appeal Type - Professional vs Institutional
    m. Comments
    n. Reviewing Physician
    o. Decision Status

4. The claim is researched and processed for payment/denial based on the information submitted by the provider.

5. If the provider dispute involves a claim and it is determined to be in favor of the provider, IPA pays any outstanding money due, including any required interest or penalties, within five business days of the decision. Accrual of the interest and penalties, when applicable, commences on the day following the date by which the claim should have been processed.

6. Once a determination is made, a resolution letter is generated and mailed to the provider as well as an EOP and check, if applicable.

7. Any interest due to the provider will be paid on the same claim *(Refer to Interest P&P).*

Adriana Regalado

Vice-President of Claims - 1/2021

SUBJECT: PDR – Non-Contracted Provider **Policy #:** CLM041
DEPARTMENT: Claims

Effective Date: June 2006
Last Revision: July 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; April 2013; November 2013; December 2014, January 2015
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021 , January 2023

SCOPE:
This policy applies to **Medicare Lines of Business** and is applicable only when an IPA is delegated by the Health Plan to process disputes or payment appeals from Non-Contracted Providers.

PURPOSE:
To ensure a process by which Non-Contracted Providers (NCPs) have clear and reliable access to a Provider Payment Dispute Resolution (PDR) process that meets the requirement of the Centers for Medicare & Medicaid Services (CMS).

POLICY:
It is the policy of HealthSmart MSO (HSMSO, on behalf of the IPA to provide and maintain a process that addresses the receipt, handling, and disposition of a PDR for NCPs in accordance with applicable statutes, regulations, contractual requirements, and the terms and conditions of this policy.

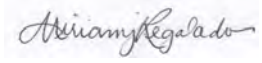
A. HSMSO Claims Department shall accept, track, and report all Non-contracted PDRs, excluding those processed by the Claims Department

B. NCPs may file a PDR within one hundred and twenty (120) days from the receipt of the Remittance Advice (RA) for level of payment disputes (The notice of initial determination is presumed to be received five (5) days from the date of the RA unless there is evidence to the contrary).

C. NCPs may file a second level written request to the health plan if they disagree with the decision on the first level dispute by mail within one hundred 180 calendar days of written notice from HSMSO Claims Department.

D. HSMSO shall provide all parties to a PDR with reasonable opportunity to present evidence or allegations of fact or law related to the issue in dispute in person or in writing. IPA shall take all evidence into account when making its decision.

E. The Claims Department shall process PDRs involving payment disputes about the payment being less than paid by Medicare fee-for-service, or payment for a different service than billed, within thirty (30) calendar days after receipt of such appeal.



Vice-President of Claims - 1/2021

F. The Claims Department shall inform the NCP in the notice of PDR decision of his or her right to file for reconsideration under the CMS provider payment dispute process with an Independent Review Entity (IRE).

G. HSMSO shall process PDRs, including instances where there is a disagreement between a non-contracted provider and HSMSO's decision to pay for a different service than billed.

H. HSMSO shall notify the NCP of the PDR process in the following manner:

1. Remittance Advice
2. HSMSO/IPA website
3. Upon the NCP's request

I. In the event HSMSO receives a dispute that is being used to challenge a payment denial that results in "zero" due to the provider, HSMSO shall forward the dispute to the applicable health plan by the next business day for processing as an appeal.

J. Upon forwarding the dispute as defined in item H, the claims examiner shall enter the assigned code into the system noting that the dispute was forwarded to the respective health plan. This will provide HSMSO with the ability to track and report the forwarded disputes.

PROCEDURE:

A. Submission of PDR request involving Claims payment dispute:

1. NCP shall submit the initial payment dispute in writing within the required timeframe and shall include:
    a. The Member's name;
    b. Medicare health insurance (HIC) number;
    c. specific service(s) and/or items(s) for which the PDR is being requested;
    d. date(s) of the service;
    e. name and signature of the party or the representative of the party filing the request; and
    f. any additional information that supports the request, including but not limited to medical records.

2. PDRs may be submitted to
   HSMSO
   : Attn: Appeals
   P.O. 6301 Cypress
   CA 90630-0018

   Note: If the dispute is being used to challenge a payment denial that results in "zero" due to the provider, HSMSO shall forward the dispute to the applicable

Adriana Regalado

Vice-President of Claims - 1/2021

health plan by the next business day for processing as an appeal. The appeal shall be directed to the applicable health plan's appeal unit.

3. The Claims Department shall notify the provider if any required information, is missing. If the information is not submitted within the required timeframe, HSMSO shall process the dispute accordingly.

   Note: If contracted IPA is not delegated for NCP appeals by the respective Health Plan, HSMSO shall forward the request to the respective Health Plan by the next business day, and the following steps shall not apply. If IPA is not delegated for NCP Appeals/PDRs then all references to IPA shall revert to the applicable Health Plan.

4. A PDR handled by the Claims Department.
   a. For disputes related to the amount of payment or payment for services different than billed (down-coding), the NCP shall file the dispute with the payer as identified on the RA, either IPA or the Health Plan.

5. The Claims Department shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request. The PDR must include the name, address and time limits for filing with the IRE.

6. NCP may file with the IRE if the NCP is not satisfied with the decision issued by the Claims Department, or a decision is not issued within the thirty (30) calendar day time limit.

7. Upon verification that the request meets criteria for processing as a PDR, HSMSO shall send an NCP an Acknowledgement letter and a Waiver of Liability form, if necessary, within five (5) business days after receipt of the request.

8. If the NCP fails to submit a signed Waiver of Liability form after written and two (2) verbal requests to HSMSO, HSMSO shall forward the request to the IRE for dismissal.

9. IPA shall commence review of the PDR upon receipt of the signed Waiver of Liability form and the review shall be completed within sixty (60) days of that date.

10. Upon completion of review of the PDR, HSMSO shall send a resolution letter to the NCP informing the NCP of the review decision within sixty (60) calendar days of receipt of the request or the signed Waiver of Liability form, whichever is received later.

11. Failure of HSMSO to provide the NCP with a decision within the sixty (60) day

Adriana Regalado

Vice-President of Claims - 1/2021

period constitutes an adverse decision and HSMSO, on behalf of the contracted IPA shall forward the appeal to the IRE for review.

12. A PDR decision which upholds in whole or part the initial denial shall be forwarded to the IRE for review.

Adriana Regalado

Vice-President of Claims - 1/2021

13. HSMSO shall document all actions taken related to the PDR request in the system including, but not limited to:
    a. Provider's name;
    b. Date received;
    c. Name of staff that received the complaint;
    d. Designated contact person;
    e. Description of the Complaint;
    f. Date; and Disposition

B. PDR Review

1. HSMSO, on behalf of the contracted IPA shall designate an individual other than the person involved in making the initial Organization Determination to review a request for Reconsideration

2. If HSMSO based the original denial on a lack of medical necessity, a physician with expertise in the field of medicine that is appropriate for the requested service shall review the request for Reconsideration. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty or subspecialty as the treating physician.

3. If the request for Reconsideration involves emergency services, HSMSO shall apply the prudent layperson standard when reviewing the PDR.

4. The Claims staff shall present the PDR request to the appropriate reviewer for decision.

5. The Claims staff shall document the decision made by the reviewer, the rationale for the decision, and the signature of the claims staff who presented the case in the appropriate section of the PDR documentation section.

6. If, upon PDR review, HSMSO completely reverses its adverse Organization Determination, HSMSO staff shall:
    a. notify the Provider of the decision in writing;
    b. instruct the Claims staff to adjudicate the claim for payment;
    c. verify that payment was made through the claims system or that a retro-authorization was issued;
    d. ensure that the Claims staff adjusts the claim for payment within thirty (30) calendar days after the date of receipt of the request for PDR;
    e. ensure that the NCP's case file includes documentation of payment and retro-authorization; and
    f. note the PDR as "closed" in the PDR/Appeals database.

Adriana Regalado

Vice-President of Claims - 1/2021

7. If, upon PDR review, HSMSO affirms, in whole or in part, the adverse Organization Determination, HSMSO on behalf of the contracted IPA shall take the following actions:
    a. Claims staff shall notify the NCP who requested the PDR within one (1) business day after HSMSO makes the PDR decision but not more than sixty
    (60) calendar days after receipt of the request for PDR or receipt of the signed Waiver of Liability, including notice that HSMSO on behalf of the contracted IPA forwarded the Appeal to the IRE.
    b. Claims staff shall mail a copy of the case file and the Reconsideration Background Data Form and Case Narrative Form with cover letter to the IRE, if delegated by the respective Health Plan for Appeals, within five (5) calendar days after IPA makes the PDR decision or within sixty (60) calendar days after receipt of the request for PDR, whichever is less.

C. IRE Determination

1. The IRE shall make a decision on an Appeal in accordance with its CMS contracted timeframe.

2. The IRE may request additional information from IPA within a specified timeframe using the IRE Request for Additional Information Form. Upon receipt of such request, HSMAO on behalf of the contracted IPA shall make every effort to provide the requested information within the specified timeframe using the Letter to IRE with Additional Information.

3. If the IRE upholds HSMSO's adverse Organization Determination, it shall notify HSMSO or the IPA and/or the Health Plan and the NCP of such decision in writing. Upon receipt of such notice, the Claims staff shall place the notice in the NCP's Appeal file.

4. If the IRR reverses or partially reverses HSMSO's adverse Organization Determination, the Claims staff shall:
    a. notify the NCP of the IRE's decision and compliance with IRE decision;
    b. coordinate with the HSMSO Claims Department to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;
    c. send a notification of compliance letter to the IRE; and
    d. document all activities in the Appeal tracking system.

D. Administrative Law Judge (ALJ) Hearing

1. A NCP that provided Covered Services to a Member has the right to a hearing before an ALJ if the projected value of the disputed service after Reconsideration is one hundred and sixty dollars ($160) or more, as determined by Medicare regulations and the ALJ.

2. A NCP shall request an ALJ hearing by submitting such request in writing to the contracted IPA, HSMSO, or the IRE.

3. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision, the NCP may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the NCP cannot meet the timeframe in accordance with Title 20 of the Code of Federal Regulations, Section 404.911.

4. If HSMSO receives a request for an ALJ hearing from a NCP, the staff shall forward the Member Request for ALJ Hearing (Exhibit 23) to the IRE. The IRE shall compile and forward the NCP's file to the ALJ.

5. The contracted IPA nor HSMSO shall not have the right to request an ALJ hearing, but may remain a party to the hearing.

6. If the ALJ reverses HSMSO's initial adverse Organization Determination in whole or in part, HSMSO shall pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the Organization Determination, unless it requests Medicare Appeals Council (MAC) review of the ALJ decision.

7. If the contracted IPA or HSMSO requests MAC review of the ALJ decision, HSMSO may wait for the MAC's decision before it authorizes or provides the disputed service; and

8. Inform the IRE when it effectuates the decision.

E. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision may request a MAC review of the ALJ decision or dismissal

2. A party requesting a MAC review shall submit such request:
    a. In writing directly to the MAC; and
    b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If the contracted IPA or HSMSO receives a NCP's request for a MAC review, HSMSO shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to the MAC.

4. If the contracted IPA or HSMSO requests a MAC Review, it shall:

a. Submit a Request for MAC Hearing and a complete case file to the MAC;
b. Concurrently notify the NCP of HSMSO's request by sending the Provider a copy of the request and all information submitted to the MAC; and
c. Notify the IRE of IPA's request

5. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision or dismissal. The MAC shall notify all parties in writing of its decision to initiate such review.

6. If the MAC reverses HSMSO's initial adverse Organization Determination in whole or in part, IPA shall:
   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and
   b. Inform the IRE when it effectuates the decision

F. Judicial Review

1. Any party, including HSMSO, may request a judicial review of an ALJ decision if:
   a. The MAC denied the party's request for review; and
   b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including HSMSO, may request a judicial review of a MAC decision if:
   a. The MAC denied the party's request for review; or
   b. It is the final decision of CMS; and
   c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain a judicial review unless the MAC has acted on the case.

4. In order to obtain a judicial review, a party shall file a civil action in a district court of the United States in accordance with Section 205(g) of the Social Security Act. AIC must be greater than $1,560.

5. HSMSO shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses HSMSO's initial adverse Organization Determination in whole or in part, HSMSO shall:
   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the judicial review reversing the Organization Determination; and
   b. Inform the IRE when it effectuates the decision.



G. Appeals Data

1. The HSMSO Quality Improvement Committee shall track, trend, and analyze Appeals data, taking into account information from other sources including, but not limited to, Grievances, and Member satisfaction survey result.

2. The QI Committee shall present aggregate information to the HSMSO Board of Directors with recommendations for interventions, as appropriate

ATTACHMENTS:
Provider Dispute Request Form

REFERENCES:
Center for Medicare & Medicaid Services Letter, Provider Payment Dispute Resolution for Non-Contracted Providers, January 4, 2010.
HPMS Memo on Provider Payment Dispute Resolution for Non-Contracted Providers, Jan 4, 2010
Medicare Managed Care Manual, Chapter 13
Title 42, Code of Federal Regulations, Section 422.560 ct. seq
MA Payment Guide for Out of Network Payments, June 1, 2011

Adriana Regalado
Vice-President of Claims - 1/2021

SUBJECT: **Claims Provider Appeals** **Policy #:** CLM045
DEPARTMENT: Claims

Effective Date: March 2015
Last Revision: March 2015, May 2019
Last Review Date: January 2016, January 2017, April 2018, January 2020, January 2021, January 2023

SCOPE:
This policy applies to all Lines of Business.

PURPOSE:
To provide a clear process for the management of appeals.

POLICY:
It is the policy of HealthSmart (HSMSO) to ensure that second level Appeals are handled appropriately.

PROCEDURE:
HSMSO is not delegated for second level provider Appeals and must ensure that both providers and enrollees are well informed of the process to follow.

Commercial and Medi-Cal Lines of Business
The IPAs, therefore HSMSO)are not delegated for second level provider Appeals and must forward to the health plans.

1. A provider who has been denied payment for services, or feels that the claim has been underpaid, or who has other claims or billing related issues, must first file a dispute with the HSMSO, as outlined in the Claims Policies and Procedures: CLM040 - Provider Disputes. Providers are also informed via the EOP of where to send their first level appeal/dispute. The appeal/dispute form and all other information is found in HSMSO's website: http://www.healthsmartmso.com

2. Providers who do not agree with HSMSO's dispute determination may submit a second level appeal within 180 days to the member's health plan if they disagree with the written determination rendered by HSMSO for any appeal involving payment, denial, adjustment, or contesting of a claim, including overpayments, payment rates, billing issues or any other claim reimbursement decision that they believe were unfairly upheld or underpaid.

Medicare Non-Contracted Provider Appeals:
1. A provider who has been denied payment for services, or feels that the claim has been underpaid, or who has other claims or billing related issues, must first file a dispute with the HSMSO, as outlined in the Claims Policies and Procedures :CLM040 - Provider Disputes. Providers are also informed via the EOP of where to send their first level appeal/dispute. The appeal/dispute form and all other

Adriana Regalado
Vice-President of Claims - 1/2021

information is found in HSMSO's website: http://www.healthsmartmso.com

2. Non-contracted providers, pursuant to federal regulations governing the Medicare Advantage program may request reconsideration of a Medicare Advantage plan denial determination. Requests for reconsideration must be submitted within 60 days of the date of the remittance advice/EOP and a signed waiver of liability (WOL) statement will be required.

3. The providers are informed via remittance advice/EOP, as well as the HealthSmart's website http://www.healthsmartmso.com/Links.php and view Claim Resources for more information as well as the waiver of liability form.

Adriana Regalado

Vice-President of Claims - 1/2021

This section applies to the following CalOptima programs:

Medi-Cal

H6: PM160 INFORMATION ONLY FORM — FULL ASSESSMENT BILLING TIPS

All preventive service visits for CalOptima members under age 21 are eligible for additional funding when submitted on a PM160 Information Only form (PM160 INF — brown form) for dates of service through June 30, 2018. For dates of service on or after July 1, 2018, the PM160 Information Only form will no longer be accepted and providers must use the CMS1500 or UB04 claim form for all preventive services.

Please fill out each PM160 INF completely, using the guidelines below. For more specific information, refer to the Providers section of CalOptima's website.

BILLING TIPS FOR PM160 CLAIMS — FULL ASSESSMENT

1. **Required Information Needed for Completing FULL ASSESSMENT Claims**
   a. Patient name — first and last
   b. Provider name and address
   c. Birth date
   d. Provider number
   e. Age
   f. Provider signature (signature on file or signature stamp is not acceptable)
   g. Sex
   h. Date signed
   i. Responsible person — name and complete address
   j. Member identification number (check eligibility each time)
   k. Ethnic code
   l. Height (exception: child in wheelchair with appropriate explanation given in comments)
   m. Date of service
   n. Patient visit
   o. Diagnosis code
   p. Type of screen
   q. Tobacco questions answered (all three)

2. **Billing Tips for Assessment Portion of Claim:**
   a. Column A — If marked, should have a fee, unless appropriate explanation given in comments (e.g., sent to lab, observation, etc.).
   b. Column B — If marked, should not have a fee. The exception is line 12 (TB Mantoux). This can have a fee if in comments it is explained that patient did not return for follow up.
   c. Columns C and D — If marked, must be marked with a follow-up code (listed on claim, numbers are 1–6) and should have a fee, unless appropriate explanation given in comments.
   d. Other Tests — Must have code number and name of test
   e. Column A may not be marked along with Columns C or D for the same line.
   f. Lines 9 and 10 may not be charged for at the same time.

There must be a checkmark on each line 1–12 under one of the columns (A–D) to indicate outcome of procedure.

3. **Billing Tips for Immunization Portion of Claim:**
    a. Immunization code and description required if immunizations were given
    b. Columns A and B — If marked, must have a fee
    c. Columns C and D — If marked, may not have a fee

4. **Billing Tips for Completing the Immunization Section**
    a. Immunization code and description if immunizations were given
    b. Columns A and B — Must have a fee
    c. Check the patient age with the immunization code used
    d. A complete list of immunization codes is available on CalOptima's website at www.caloptima.org/.

5. **Claims Submission and Provider Dispute Process**
    a. All pediatric preventive services claims must be submitted for payment to CalOptima for payment. Include Copy 1 (white) and Copy 2 (yellow) with the completed PM160 INF.
    b. Submit PM160 INF claims and provider disputes to:

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

    c. Providers can check eligibility and/or claims status on CalOptima's website by accessing CalOptima Link through the Providers section.
    d. For instructions on how to complete a PM160 INF claim form, refer to CalOptima's website at www.caloptima.org/.
    e. For more complex claims status inquiries or any questions regarding submission of PM160 INF claims, call the PPS Claims Unit at **714-246-8885**.

This section applies to the following CalOptima programs:

Medi-Cal

H7: PM160 INFORMATION ONLY FORM AND CHDP — BILLING TIPS FOR PARTIAL ASSESSMENT AND IMMUNIZATIONS

All preventive service visits for CalOptima members under age 21 are eligible for additional funding when submitted on a PM160 Information Only form (PM160 INF — brown form) for dates of service through June 30, 2018. For dates of service on or after July 1, 2018, the PM160 Information Only form will no longer be accepted and providers must use the CMS1500 or UB04 claim form for all preventive services.

Please fill out each PM160 INF completely, using the guidelines below. For more specific information, please refer to the Providers section of CalOptima's website.

PM160 INFORMATION ONLY BILLING TIPS FOR PARTIAL AND IMMUNIZATION ONLY CLAIMS

1. **Required Information Needed In Completing IMMUNIZATION SECTION Claims**
    a. Patient name — first and last
    b. Diagnosis code
    c. Birth date
    d. Provider name and address
    e. Age
    f. Provider NPI number
    g. Sex
    h. Date signed
    i. Responsible person — name and complete address
    j. Member identification number (check eligibility each time)
    k. Ethnic code
    l. Provider signature (signature on file or signature stamp is not acceptable)
    m. Date of service

2. **Billing Tips for Completing the Immunization Section**
    a. Immunization code and description are required if immunizations were given.
    b. Columns A and B — Must have a fee

    Check the patient age with the immunization code used. A complete list of immunization codes is available in CalOptima's Pediatric Preventive Services Resources in the Providers section of CalOptima's website.

For a PM 160 claim form with date of service 07/01/18 and after: CalOptima will reject invalid claim form to the provider and the provider must forward correct claim form to the appropriate health network. Contact your contracted health network(s) regarding claims processes and procedures.

FOR CHDP CMS-1500 OR UB-04 CLAIM FORMS BILLING TIPS

CalOptima is transitioning from the PM 160 INF form billing two-character CHDP codes in compliance with the Confidential Screening Billing Report to HIPAA regulations and billing with CPT-4 codes on the CMS–1500 or UB-04 claim forms or electronic equivalent.

3. Identify CHDP Services on CMS–1500 form
    a. Code 3 (CHDP Screening Related) in Box 24H: EPSDT Family Plan Field
    b. Member's age under 21
    c. CPT–4 Codes
    d. Diagnosis related to routine health examination

4. Identify CHDP Services on the UB-04 claim form:
    a. Code A1 (EPSDT/CHDP in Box 18-24: Condition Codes field
    b. Member's age under 21
    c. CPT-4 Codes
    d. Diagnosis related to routine health examination

CHDP CPT-4 Code Conversion available on DHCS website: http://files.medi-cal.ca.gov/pubsdoco/chdp/articles/25768.02_Cd_Conv_Table.pdf

For Vaccines for Children, immunization codes should be billed with modifier SL to allow for administration fee only.

1. **Claims Submission and Provider Dispute Process**
   All CHDP (otherwise known as pediatric preventive services) claims must be submitted for payment to CalOptima for payment. Include Copy 1 (white) and Copy 2 (yellow) with the completed PM160.

   Submit PM160 claims and provider disputes to:

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

    a. Providers can check eligibility and/or claims status on the CalOptima Link located on CalOptima's website at www.caloptima.org/.
    b. For instructions on how to complete a PM160 INF Claim Form, refer to the PPS Resources page located in the Providers section of CalOptima's website.
    c. For more complex claims status inquiries or any questions regarding submission of PM160 INF claims, call the PPS Claims Unit at **714-246-8885**.

PHARMACY AND PRESCRIBER INFORMATION

SUBJECT: Pharmacy Management/Review **Policy #:** UM 21
DEPARTMENT: Utilization Management

Effective Date: July 16, 2000
Last Revision Date: March 21, 2022
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure appropriate use of pharmaceuticals and compliance with health plan formularies.

POLICY:

Members will be referred to contracted pharmacies for their medication needs. The physician will do his best to adhere to the formulary of the member's health plan, taking in consideration any allergies the member may have, and the medical necessity of the medication prescribed. Non-formulary medications may require a separate authorization from the plan's pharmacy network administrator prior to dispensing.

With some health plans, some medication tiers may also require an authorization from a pharmacy network administrator. The providers will comply with the authorization guidelines of the pharmacy network administration for all non-formulary and medication tiers.

Where delegated pharmacy medical decision review, a physician will review for medical necessity prior authorization requests for pharmacy requests requiring step therapy.

All referrals that include an injectable to be given during visit will be processed within 24 hours of receipt. Providers requesting the injectable will be notified within 1 business day of the decision with the decision.

The UM Committee will monitor appropriate use of pharmaceuticals according to the contract with the individual health plans. In contracts where pharmacy utilization is not delegated to the medical group/IPA, appropriateness of pharmaceutical use will be evaluated during the medical record review process.

In the event that the medical group is given pharmacy utilization data from the health plan for review, the UM Committee will review its activity and make recommendations to providers, if issues are detected. Any abuse or fraudulent activity suspected or detected will be immediately brought to the attention to the health plan for further investigation.

DEFINITIONS:

None required.

PROCEDURE:

A. When the physician has a need to prescribe a non-formulary medication, he must first fill-out a Non-Formulary Drug request form and submit to the health plan's pharmacy network administrator. If the request is needed urgently, the provider must document the urgent need.

B. When UM Committee is supplied with pharmaceutical usage data, the information will be reviewed for appropriateness.

C. Any issues identified, such as cost comparison between generic vs. brand name will be brought to the attention of the individual provider as part of provider education.

D. Any fraudulent or abusive activity will be immediately brought to the attention of the health plan for further investigation.

FORMS:

None required

REFERENCES:

NCQA UM 11 Procedures for Pharmaceutical Management

CalOptima Health

Cultural Competency Training

Our Mission

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

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Objectives

- After completing this course, you will be able to:
  - Describe the complex and diverse population of members and potential members of CalOptima Health and the service area's geography
  - Distinguish between race, ethnicity and culture
  - Understand and articulate selected health inequities
  - Recognize the needs of a diverse membership population
  - Examine and explain how bias and stigma lead to negative health outcomes
  - Describe CalOptima Health's language, text-to-speech (TTY) and braille services for members

CalOptima Health

CalOptima Health

Terminology and Concepts

Race, Ethnicity and Culture

- Race and ethnicity are categories that are artificially created by society and not based on biology. They are used to categorize and characterize seemingly different groups of people
  - Race: Groups that humans are often divided into based on physical traits assumed to be common among people of shared ancestry
  - Ethnicity: Large sets of people grouped according to common racial, national, tribal, religious, linguistic or cultural background
  - Culture: The customary beliefs, social forms and material traits of a group

CalOptima Health

What Is (and Isn't) Cultural Competency?

- In health care, cultural competency is our ability to deliver care and services in a way that respects and honors the diverse cultural, racial, ethnic and other populations without stigma or barriers
- It is not about knowing a checklist of traits for each culture
  - Food, religion, geography and language can be part of culture, but there will always be diversity within a culture and knowing a checklist does not make you culturally competent

Adapted from: Culturally Responsive TB Education and Training Webinar, Part 1, CDC

CalOptima Health

Moving From Competency to Humility

- "Cultural competence is well established in the medical and public health lexicon as a means of attending to the culturally diverse backgrounds of patients, providing person-centered care and reducing health disparities"
- "Cultural humility means admitting that one does not know and is willing to learn from patients about their experiences while being aware of one's own embeddedness in culture(s). While competence suggests mastery, humility refers to an intrapersonal and interpersonal approach that cultivates person-centered care"

CalOptima Health

Moving From Competency to Humility (cont.)

- Cultural competency and humility are part of our mission "To serve member health with excellence and dignity, respecting the value and needs of each person"

Lekas HM, Pahl K, Fuller Lewis C. Rethinking Cultural Competence: Shifting to Cultural Humility. Health Serv Insights. 2020 Dec 20;13:1178632920970580. doi: 10.1177/1178632920970580. PMID: 33424230; PMCID: PMC7756036.

CalOptima Health

Diversity, Equity and Inclusion in the Workplace

- Diversity refers to who is represented in the workforce. Examples include gender, age, ethnic and ability diversity. Diversity also includes ranges of perspectives, backgrounds and beliefs
- Equity is the fair access and resources to all people, including the norms, practices and policies that ensure fair opportunities and workplace outcomes

CalOptima Health

Diversity, Equity and Inclusion in the Workplace (cont.)

- Inclusion is how the workforce experiences the workplace and the degree to which organizations welcome all employees and enable them to contribute meaningfully

CalOptima Health

Bias and Stigma

- Bias is prejudice in favor of or against a thing, person or group compared with another. It can be implicit or explicit and can affect patients through patient-clinician communication, clinical decision-making and institutional practices
  - Implicit bias is "unconscious mental processes that lead to associations and reactions that are automatic and without intention." Implicit bias goes beyond stereotyping and leads to favorable or unfavorable treatment

CalOptima Health

Bias and Stigma (cont.)

- Explicit bias includes "preferences, beliefs and attitudes of which people are generally consciously aware, endorsed and can be identified and communicated"

- Stigma is an association of disgrace or disapproval with something, such as an action or condition

Vela MB, Erondu AI, Smith NA, Peek ME, Woodruff JN, Chin MH. Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. Annu Rev Public Health. 2022 Apr 5;43:477-501. doi: 10.1146/annurev-publhealth-052620-103528. Epub 2022 Jan 12. PMID: 35020445; PMCID: PMC9172268

CalOptima Health

Sex, Sexual Orientation, Identity and Expression

- Sex is generally used to describe physical sex characteristics you are born with and develop
- Sexual orientation describes whom a person is attracted to romantically or sexually
- Gender identity describes the way a person identifies themselves (i.e., who an individual knows themselves to be). This may or may not be aligned with their anatomical sex
- Gender expression is about how a person presents their identity through actions, clothing, demeanor and more

Adapted from: Sam Killerman, 2021, The Genderbread Person, www.itspronouncemetrosexual.com/

CalOptima Health

Our Commitment

- CalOptima Health ensures and promotes access and delivery of services to all members and potential members including those with limited English proficiency, diverse cultural and ethnic backgrounds, and physical or mental disabilities in a culturally competent manner regardless of sex, race, color, religion, ancestry, national origin, creed, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code Section 422.56*

*Click here to review Penal Code Section 422.56

CalOptima Health

Knowledge Check

- 1.) Knowing a list of food, religion, geography and language associated with a culture is the best way to be culturally competent
  - A.) True
  - B.) False

CalOptima Health

Knowledge Check

- 2.) _____ is about how a person presents their identity through actions, clothing, demeanor and more
  - A.) Sexual orientation
  - B.) Sex characteristics
  - C.) Gender expression
  - D.) Gender identity

CalOptima Health

Knowledge Check (cont.)

- 3.) While competence suggests mastery, humility refers to an intrapersonal and interpersonal approach that cultivates person-centered care
  - A.) True
  - B.) False
- 4.) The largest non-English speaking language for CalOptima Health members is
  - A.) Mandarin
  - B.) Spanish
  - C.) Arabic
  - D.) Khmer

CalOptima Health

Knowledge Check Answers

- 1. A.) False
- 2. B.) Gender expression
- 3. C.) True
- 4. D.) Spanish

CalOptima Health

CalOptima Health

Inequities in Health Care

Health Equity Versus Equality

- Health equity is "the attainment of the highest level of health for all people." Inequities exist when groups are unable to attain this level of health
- Equality means everyone gets the same resources, while equity means everyone has the same outcome
- Newer models of health justice focus on self-determination, recognizing that individuals have a right to determine their own destiny and may choose different outcomes based on their values

CalOptima Health

Inequities in Late-Stage Cancer Diagnosis

- Successful treatment of cancer increases with early-stage diagnosis, as late-stage diagnoses mean cancer is harder to overcome
- Data shows that across four cancer types (breast, cervical, colorectal and lung), in comparison to the size of their member population:
  - Asian members were overrepresented in late-stage diagnoses
  - Black members were overrepresented for cervical cancer
  - White members were overrepresented for breast, colorectal and cervical cancers

CalOptima Health

Population Needs Assessment

- CalOptima Health regularly conducts a Population Needs Assessment (PNA), in accordance with Department of Health Care Services (DHCS) guidelines
- The PNA looks at measures of health care quality to uncover disparities by factors like race/ethnicity, age and geography

CalOptima Health

Population Needs Assessment (cont.)

- Strategies that promote population health can intentionally be focused on subpopulations where disparities exist. This allows for better use of funds and helps ensure programs are tailored to any cultural needs of the population

CalOptima Health

Addressing Inequities

- The 2023 PNA report found that two cancer screening measures showed meaningful inequities:
  - The breast cancer screening rate among Chinese members was the lowest group at 46.71%
  - The cervical cancer screening rate among Korean members was the lowest at 42.24%

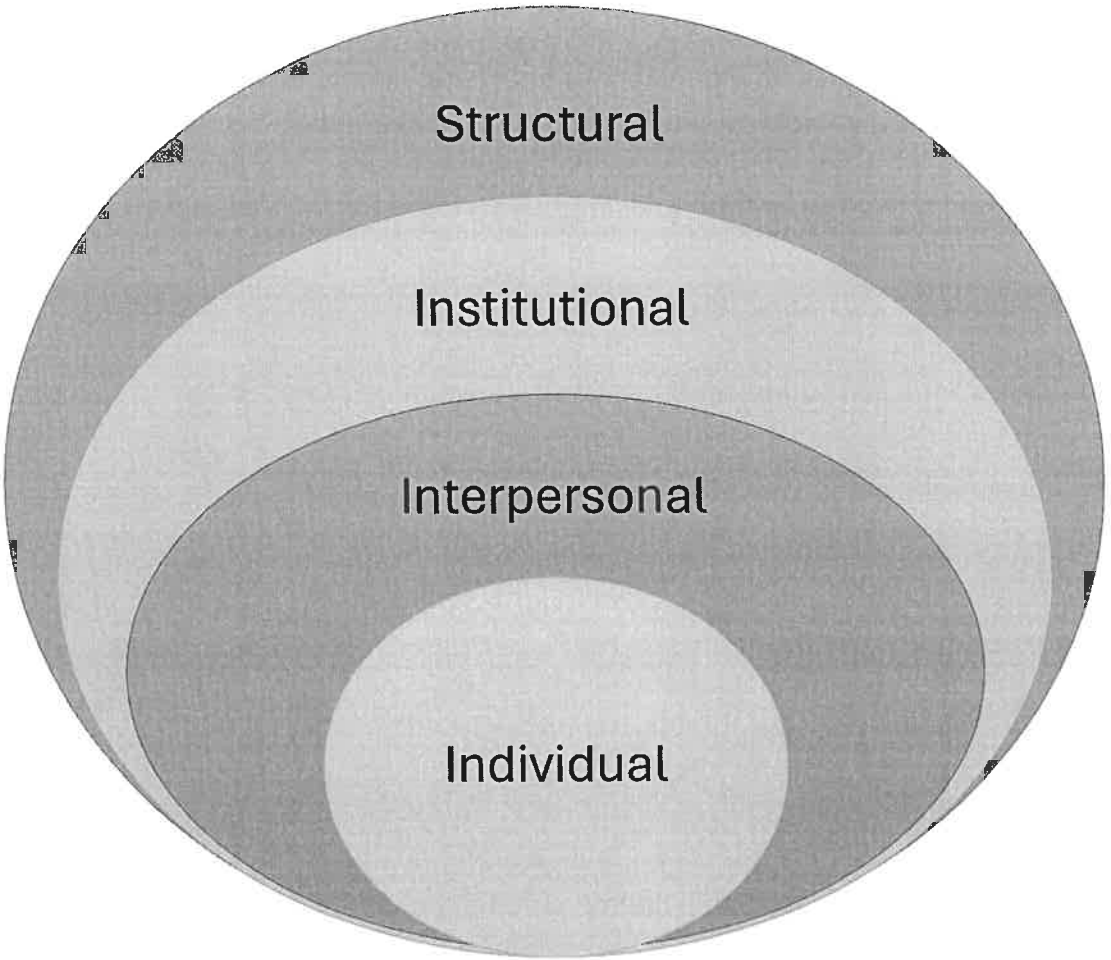
CalOptima Health

Addressing Inequities (cont.)

- The Comprehensive Community Cancer Screening and Support Program partners with external stakeholders to fight against cancer. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses
  - Breast Cancer Screening pilot with City of Hope
  - Joined Orange County Cancer Coalition
  - Sharing information about local mobile mammography community events
  - Digital and print advertisement, social media campaigns

CalOptima Health

Levels of Racism



CalOptima Health

Levels of Racism (cont.)

- **Individual Racism:** Prejudgment, bias or discrimination based on race by an individual
- **Interpersonal Racism:** Occurs between individuals. Once we bring our private beliefs into interaction with others, racism becomes interpersonal
- **Institutional Racism:** Policies, practices and procedures that work better for white people than for people of color, often unintentionally

CalOptima Health

Levels of Racism (cont.)

- **Structural Racism:** A history and current reality of institutional racism across all institutions, combining to create systems that negatively impact communities of color

CalOptima Health

Institutional Racism and Implicit Bias in Health Care

- Various research studies have highlighted how institutional racism and bias can lead to reduced quality of care for Black patients
- Three research articles showed how clinician misperception led to Black patients receiving lower quality care for pain compared to their white counterparts
- These findings highlight the importance of acknowledging and overcoming bias

CalOptima Health

Impact of Institutional Racism and Implicit Bias in Health Care

- CalOptima Health staff
  - How does CalOptima Health mitigate the impacts of institutional racism and biases through equitable hiring practices and promotional opportunities?
  - What mentorship opportunities develop staff who aspire to lead?
  - How are diverse voices at the table invited to guide program development that benefits the communities that they are from and serve?

CalOptima Health

Impact of Institutional Racism and Implicit Bias in Health Care (cont.)

- Network providers
  - How do providers' implicit biases impact clinical decision-making and care?
  - How are provider offices welcoming to people from different backgrounds?
  - Are providers and their staff reflective of the community they serve?

CalOptima Health

Impact of Institutional Racism and Implicit Bias in Health Care (cont.)

- Contractors, subcontractors and downstream subcontractors
  - Do services unintentionally exclude or disadvantage certain groups?
  - Are contractors thoughtful about designing products in an inclusive manner?

CalOptima Health

Workforce Diversity

- Having a diverse workforce means having health care professionals, trainees, educators and researchers of varied race, ethnicity, gender, disability, social class, socioeconomic status, sexual orientation, gender identity, primary spoken language and geographic region
- While the U.S. patient population has grown in diversity, physician workforce diversification is occurring at a much slower rate. This is especially true among Black, Latino, and Native American physicians

CalOptima Health

Workforce Diversity (cont.)

- Institutional racism is experienced in places of higher education, where Black, Latino and Native American aspiring clinicians face discrimination that makes achieving advanced education harder

Togioka BM, Duvivier D, Young E. Diversity and Discrimination in Healthcare. [Updated 2023 Aug 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-.Salsberg E, Richwine C, Westergaard S, et al. Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce. JAMA Netw Open. 2021;4(3):e213789. doi:10.1001/jamanetworkopen.2021.3789

CalOptima Health

CalOptima Health's Commitment to Workforce Diversity

- CalOptima Health is committed to attracting, hiring and retaining a diverse staff while honoring unique experiences, identity and perspectives. Our organization strives to create and maintain a workplace environment that is inclusive, equitable and welcoming
- CalOptima Health offers bilingual pay, a supplemental pay to staff who are proficient in threshold languages within our population, as this helps us to better serve our members

CalOptima Health

CalOptima Health's Commitment to Workforce Diversity (cont.)

- CalOptima Health will invest $50 million over five years in Health Care Workforce Development
  - Support the education, training, recruitment and retention of diverse safety net providers in Orange County

CalOptima Health

CalOptima Health

Factors and Considerations in Serving Diverse Populations

Intersectionality

- Intersectionality refers to the overlap of various identity factors, such as race, ethnicity, social class, nationality, gender, sexuality and ability
- Examples:
  - Indigenous women who are missing
  - Persian transgender men
  - Disabled lesbians in rural communities
  - Black veteran entrepreneurs
  - Older adults with ADHD on Medi-Cal
  - White people living in poverty

Adapted from Drew, C, PhD. February 17, 2023, 15 Examples of Intersectionality. Helpful professor. helpfulprofessor.com/examples-of-intersectionality

CalOptima Health

Honoring Differences and Similarities

- All people regardless of differences or similarities should be served with excellence and dignity, respecting the value and needs of each person
- CalOptima Health staff have similarities and differences within our organization, just like we have with our members — this is an asset

CalOptima Health

Honoring Differences and Similarities (cont.)

- Ensure that programs, policies and practices recognize and reflect the diversity of our membership
- Workforce diversity is an important factor in improving patient outcomes because having a provider who understands you and your experience increases patient experience
  - Literature has shown that, especially with Black patients, satisfaction and communication are improved with patient-provider race concordance

Shen MJ, Peterson EB, Costas-Muñiz R, Hernandez MH, Jewell ST, Matsoukas K, Bylund CL. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. J Racial Ethn Health Disparities. 2018 Feb;5(1):117-140. doi: 10.1007/s40615-017-0350-4. Epub 2017 Mar 8. PMID: 28275996; PMCID: PMC5591056.

CalOptima Health

Diversity Within Groups

- Middle Eastern and North African (MENA) people have historically been identified as "white" by the US Census. However, this group is diverse:
  - Nationality: Israeli, Palestinian, Egyptian, Iranian
  - Ethnicity: Hebrew, Arab, Persian
  - Language: Farsi, Hebrew, Arabic
  - Religion: Jewish, Muslim, Christian, areligious

CalOptima Health

Diversity Within Groups (cont.)

- When understanding characteristics of other cultures, it is important to treat each person as an individual and use "person-centered care" principles that focus on centering the member's/patient's needs in their own care

CalOptima Health

Perceptions of Health and Death

- Cultural health beliefs affect the way members view health, illness and death
- Dignity should be given to members' beliefs, experiences and values as it relates to their health
- Some cultures consider discussion of impending death to be inappropriate and insensitive
- At end-of-life, some patients may rely heavily on medical care, some rely on faith and spirituality, and others rely on both

www.ncbi.nlm.nih.gov/books/NBK493154/

CalOptima Health

Gender-Affirming Care for Transgender and Gender-Nonconforming Members

- Transgender or gender non-conforming people are those whose sex assigned at birth does not align with their identity. Discomfort or distress with this misalignment is clinically known as "gender dysphoria" and can be treated through gender-affirming care
  - The World Professional Association for Transgender Health defines gender-affirming care as "Safe and effective pathways to achieving lasting personal comfort with [members'] gendered selves..."

CalOptima Health

Gender-Affirming Care for Transgender and Gender-Nonconforming Members (Cont.)

- Intended to maximize overall health, psychological well-being and self-fulfillment
- May include but is not limited to primary care, hormonal and surgical treatments, voice and communication therapy, gynecological and urological care

- Some transgender and gender-nonconforming individuals may never seek medical transition, but still deserve an experience affirming of their identity

CalOptima Health

Culture and Health Care Interactions

- Cultural ideas, meanings and values can impact members' preferences for interacting with the health care system and care plans
  - Some patients may feel that is it culturally disrespectful to challenge their provider
  - Some cultural groups that have had historically poor treatment by the medical system may be uncomfortable in health care settings

CalOptima Health

Culture and Health Care Interactions (cont.)

- It is important that providers be flexible in meeting the needs of individual patients in a way that respects their identity
- Using communication techniques that allow the care provider to better understand the health beliefs and motivators for individuals while respecting individuality

www.ncbi.nlm.nih.gov/books/NBK216037/#:~:text=Cultural%20health%20beliefs%20affect%20how,care%20interventions%2C%20and%20treatment%20adherencehttps://www.cdc.gov/cancer/survivors/patients/complementary-alternative-medicine.htm

CalOptima Health

Alternative and Complementary Medicine

- Sometimes, members may opt for alternative (instead of) or complementary (in addition to) medicine as part of their care, such as:
  - Acupuncture
  - Tai chi, yoga, massage therapy, meditation
  - Vitamins, herbal nutritional therapies
  - Traditional cultural healing practices
- Members should always be encouraged to talk to their provider about starting any kind of treatment, including alternative and complementary therapies, to assess their safety and efficacy

www.cdc.gov/cancer/survivors/patients/complementary-alternative-medicine.htm

CalOptima Health

Health Literacy

- Literacy is defined as a set of reading, writing, basic mathematics, speech and speech comprehension skills
- Health literacy is the bridge between literacy and the health context
  - Groups with a higher likelihood of lower health literacy include:
    - Those on Medicaid
    - Men
    - Those who speak English as a second language
    - Those with cognitive disabilities
    - Those with lower educational attainment

CalOptima Health

Health Literacy (cont.)

- Personal health literacy is the degree to which individuals have the ability to find, understand and use information and services to inform health-related decisions and actions for themselves and others
- Organizational health literacy is the degree to which organizations equitably enable individuals to find, understand and use information and services to inform health-related decisions and actions for themselves and others

www.ncbi.nlm.nih.gov/books/NBK216035/https://milkeninstitute.org/sites/default/files/2022-05/Health_Literacy_United_States_Final_Report.pdf

CalOptima Health

Health Literacy (cont.)

- CalOptima Health and our partners can have a direct impact through:
  - Ensuring user readability and a sixth-grade level in member materials
  - Educating providers on health literacy principles
  - Having staff respond to member communication needs
    - Teach back is a method of patient education to confirm that you have explained things in a manner the patient understands
    - Motivational interviewing is a counseling method that helps uncover a patient's motivation for change

CalOptima Health

CalOptima Health

Disease Stigma and Homelessness: Case Study Examples

Stigma Related to Conditions

- Stigma
  - An association of disgrace or public disapproval with something, such as an action or condition
  - Negative attitudes and beliefs about people with a specific medical condition
  - Prejudice that comes with labeling an individual as part of a group that some believe to be socially unacceptable

CalOptima Health

Stigma Related to Conditions (cont.)

- Discrimination
  - The behaviors that result from negative attitudes or beliefs
  - The act of treating people living with a specific medical condition differently than those without

CalOptima Health

Stigma Related to Conditions (cont.)

- Examples
  - Assuming someone caused their own lung cancer through smoking
  - Stating that all people experiencing homelessness have mental illness
  - Believing people with developmental disabilities can not live alone

CalOptima Health

Stigma Case Study: HIV

- The human immunodeficiency virus (HIV) attacks the body's immune system
- The virus was first detected in the United States in the 1970s among gay and bisexual men
- With compounding effects of homophobia, discrimination, stigma and fear, this population has been unnecessarily disenfranchised from care

CalOptima Health

Stigma Case Study: HIV (cont.)

- HIV can affect anyone, regardless of sexual orientation, race, ethnicity, gender or age. Some groups of people are at a higher risk, and these groups merit special consideration due to particular risk factors

CalOptima Health

Stigma Case Study: HIV (cont.)

- Groups most affected are:
  - Gay, bisexual and other men who reported male-to-male sexual contact
  - People who inject drugs
  - People who exchange money for sex
  - The economically disadvantaged
  - Transgender people

CalOptima Health

Stigma Case Study: HIV (cont.)

- Today, many medical options exist for prevention and treatment of HIV. HIV is a lifelong infection with no effective cure, but it can be well-managed through proper medical care
- People with HIV can live long, healthy lives without transmitting the virus to their partners

CalOptima Health

HIV Stigma and Discrimination

- HIV stigma is the negative attitudes and beliefs about people with HIV
  - Harmful negative beliefs include:
    - Believing only certain groups of people can get HIV
    - Making moral judgments about people who take steps to prevent HIV
    - Feeling that people deserve to get HIV because of their choices
- Discrimination is the behaviors that result from stigma

CalOptima Health

HIV Stigma and Discrimination (cont.)

- Here are a few examples:
  - Provider refusing to give care to a person living with HIV
  - Refusing casual contact with someone living with HIV
  - Socially isolating a member of a community because they are HIV positive

CalOptima Health

Health Care Professionals Can Reduce Stigma

- Get the facts on HIV
  - Prevention
    - Pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)
  - Treatment
    - Anti-retroviral therapy (ART)
  - Modes of transmission (not casual contact)
  - Undetectable = Untransmittable (U=U)
- Learn how to talk about HIV
  - Use the CDC Stigma Language Guide

CalOptima Health

Health Care Professionals Can Reduce Stigma (cont.)

- Fight stigma through words and actions
  - Disrupt stigma when you witness it
  - Promote HIV testing
  - Talk about HIV to normalize the topic

Citations: https://www.cdc.gov/stophivtogether/library/stop-hiv-stigma/fact-sheets/cdc-lsht-stigma-factsheet.pdfhttps://www.cdc.gov/hiv/basics/hiv-stigma/index.html

CalOptima Health

Definition of Homelessness

- Programs serving people experiencing homelessness have criteria for inclusion in services and care. In Orange County, someone must fall into one of two categories:
  - An individual or family:
    - Lacking adequate nighttime residence
    - Possessing a primary residence that is a public or private place not designed or ordinarily used for habitation
    - Living in a shelter
    - Exiting an institution into homelessness
    - Losing housing imminently in the next 30 days
    - Fleeing domestic violence

CalOptima Health

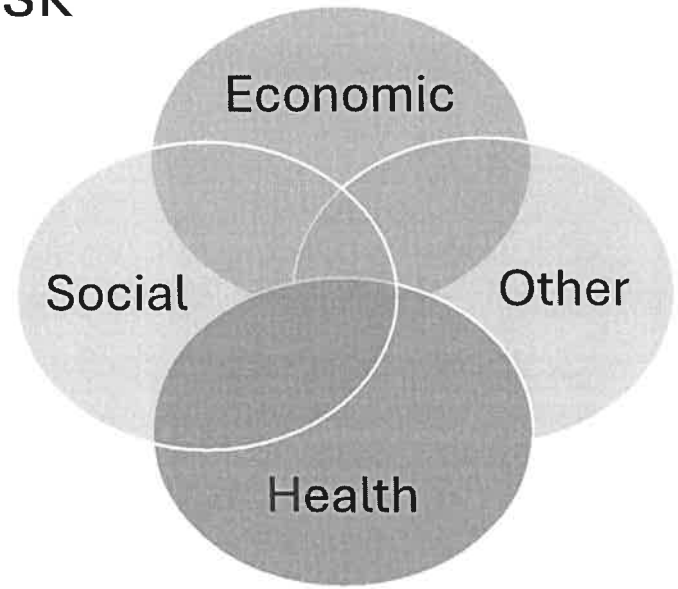
Definition of Homelessness (cont.)

- Unaccompanied youth under 25 years of age or families with children and youth defined as homeless under other federal statutes

CalOptima Health

Beyond the Definitions and Data

- Risk factors include but are not limited to poverty, poor physical and mental health, and adverse or unstable social experiences
- Definitions may not always include people who are marginally housed, "couch-surfing" or otherwise at risk



CalOptima Health

Beyond the Definitions and Data (cont.)

- Terminology evolves — you may hear people using the term "unhoused" instead of "homeless." Best practice is to use "person experiencing homelessness"
- Census counts, such as the Orange County 2022 Point in Time Summary, have limitations and may undercount people of color, LGBTQIA+ people, veterans and undocumented residents

CalOptima Health

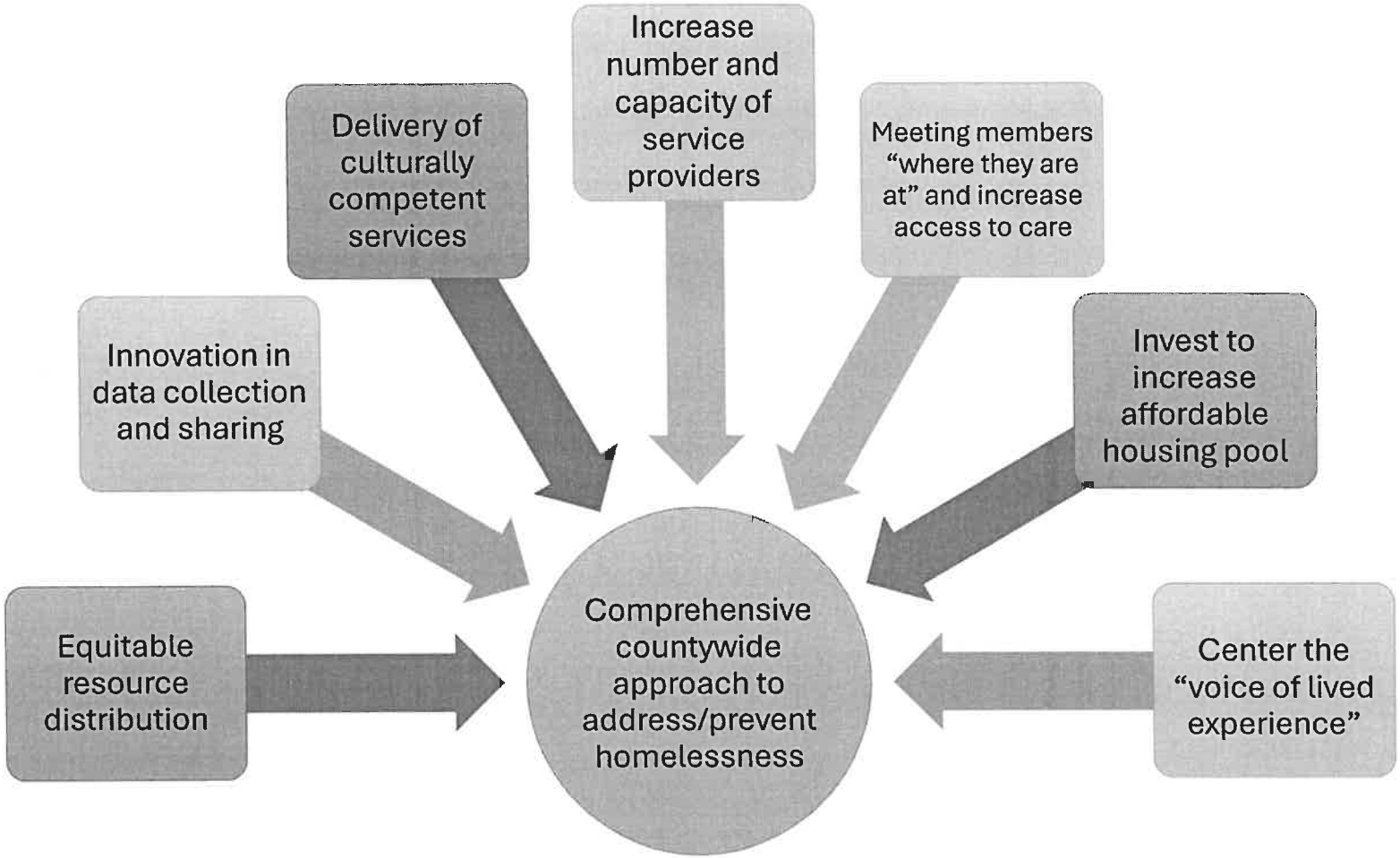
CalOptima Health's Commitment

- Prioritize projects and programs that are trauma-informed, harm-reduction oriented, sustainable, inclusive, non-residency restricted, low barrier and promote housing first

For more information on these funding opportunities and CalAIM please visit:
www.caloptima.org/en/About/CurrentInitiatives/CalAIM/FundingOpportunities

CalOptima Health

CalOptima Health's Commitment (cont.)



CalOptima Health



CalOptima Health's Language Access Services

Language Access

- A CalOptima Health member with a language preference other than English may need:
  - A health care provider, physician assistant, nurse practitioner or social worker who speaks the language
  - A professional interpreter
  - A family member
  - Appropriate in-language signage communicating the different services that are available

For more information on these funding opportunities and CalAIM please visit:
www.caloptima.org/en/About/CurrentInitiatives/CalAIM/FundingOpportunities

CalOptima Health

Language Services

- CalOptima Health members have the right to certain language services:
  - 24-hour access to no-cost interpreter (including American Sign Language, teletypewriter [TTY] or California Relay Services) at key points of contact
    - Customer Service Call Center
    - Provider settings (network capable of meeting diverse cultural needs, including many pharmacies that offer services in several languages)
    - Health Risk Assessment (HRA) and Interdisciplinary Care Team (ICT) meetings

CalOptima Health

Language Services (cont.)

- Notice of interpreter services is required
  - Provided in Member Handbook
  - Posters and flyers at care sites and member orientation setting

CalOptima Health

Language Services (cont.)

- CalOptima Health has the responsibility to ensure effective communication
  - Member information and health education materials translated in the following languages:
    - Spanish
    - Vietnamese
    - Korean
    - Farsi
    - Chinese
    - Arabic
    - Russian

CalOptima Health

Language Services (cont.)

- Members may request materials in alternative formats, including braille, digital, audio or large print

CalOptima Health

Translated Materials

- Multilingual settings and materials translated in the threshold languages are made available to members
- Written materials are translated at a sixth-grade reading level or an appropriate level determined by field testing
  - New member orientation group meetings
  - Annual newsletter
  - CalOptima Health Member Handbook
  - Explanations of Benefits (EOBs)
  - Disclosure forms

CalOptima Health

Translated Materials (cont.)

- Member education materials
- Provider listings or directories
- Marketing materials
- Form letters
- Preventive health reminders
- Member surveys
- Community resource lists

CalOptima Health

Ongoing Language Services Analysis

- CalOptima Health monitors the ability of non-English speaking members to obtain services
- Language study analysis and areas of improvement
  - Language data from CalOptima Health providers and members are used to determine provider adequacy by language for non-English speaking members
  - Language standards for each threshold language are determined
  - A plan of action for health networks or medical groups with member-to-provider ratio at 500:1 and above is developed

CalOptima Health

Organizational Support

- CalOptima Health monitors and adheres to the Culturally and Linguistically Appropriate Services (CLAS)
  - Recommendations and standards disseminated by the Office of Minority Health of the U.S. Department of Health and Human Services (HHS)
- Encourage health care organizations to implement standards like CLAS

CalOptima Health

Organizational Support (cont.)

- Aid health care providers and health care organizations to deliver culturally competent care
  - Defined by the Office of Minority Health as the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by members to the health care encounter

CalOptima Health

Knowledge Check

- 1. CalOptima Health's threshold languages are:
  - A.) English, Spanish, Vietnamese, Farsi and Korean
  - B.) English, French and Spanish
  - C.) English, Spanish
  - D.) English, Spanish, Vietnamese, Farsi, Arabic, Korean, Chinese, and Russian
- 2. CalOptima Health members have the right to certain language services
  - A.) True
  - B.) False

CalOptima Health

Knowledge Check (cont.)

- 3. Gender-affirming care is intended to:
  - A.) Improve psychological well-being
  - B.) Maximize overall health
  - C.) Promote self-fulfillment
  - D.) All of the above

CalOptima Health

Knowledge Check (cont.)

- 4. _____ is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others
  - A.) Organizational health literacy
  - B.) Personal health literacy
  - C.) Health equity
  - D.) All of the above

CalOptima Health

Knowledge Check (cont.)

- 5. HIV is:
  - A.) Treatable
  - B.) Preventable
  - C.) Curable
  - D.) All of the above
  - E.) A and B only

CalOptima Health

Knowledge Check (cont.)

- 6.) A CalOptima Health member with a language preference other than English may need:
  - A.) A health care provider, physician assistant, nurse practitioner or social worker who speaks the language
  - B.) A professional interpreter
  - C.) Appropriate in-language signage communicating the different services that are available
  - D.) All of the above

CalOptima Health

Knowledge Check Answers

- 1. C.) English, Spanish, Vietnamese, Farsi, Arabic, Korean, Chinese, and Russian
- 2. A.) True
- 3. D.) All of the above
- 4. A.) Organizational health literacy
- 5. E.) A and B
- 6. D.) All of the above

CalOptima Health

CalOptima Health

Resources and References

Additional Resources

- To schedule a language or American Sign Language interpreter:
  - Contact the member's assigned health network (if the member is in a health network)
  - Call CalOptima Health's Customer Service department
    - 24/7
    - OneCare: **1-877-412-2734** (TTY **711**), toll-free
    - Medi-Cal: **1-888-587-9099** (TTY **711**), toll-free
- To request printed member or health education materials in alternate formats contact CalOptima Health's Customer Service department

CalOptima Health

Authorities

- American Psychiatric Association
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Kaiser Family Foundation
- McKinsey & Company
- Merriam Webster's New World College Dictionary, Fifth Edition
- Medicare Managed Care Manual, Chapter 4
- National Center for Cultural Competence

CalOptima Health

Authorities (cont.)

- National Center for HIV, Viral Hepatitis, STD and TB Prevention
- National Geographic
- National Institutes of Health
- National Quality Forum
- Office of Minority Health, National Standards on Culturally and Linguistically Appropriate Services
- Orange County Continuum of Care
- Public Policy Institute of California

CalOptima Health

Authorities (cont.)

- Title 11.6, Civil Rights, California Legislation, Section 422.56
- Title 42, Code of Federal Regulations, Section 422.112
- Title 45, Code of Federal Regulations, Section 84.52
- Title 9, Code of Federal Regulation, Section 1810.410 (f) (3)
- Urban Indian Health Institute
- U.S. Census Bureau, QuickFacts

CalOptima Health

Authorities (cont.)

- World Professional Association for Transgender Health, Standards of Care

CalOptima Health

References

- OneCare Physician Medical group (PMG) Service Agreement
- CalOptima Health Policy AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training
- CalOptima Health Policy EE.1103: Provider Network Training
- CalOptima Health Policy GG.1517: Transgender Services
- CalOptima Health Model of Care

CalOptima Health

CalOptima Health

Stay Connected With Us

www.caloptima.org

CASE MANAGEMENT

HEALTHSMART MANAGEMENT SERVICES ORGANIZATION, INC.

2026 CASE MANAGEMENT PROGRAM

I. INTRODUCTION:

To establish a program to ensure that medically necessary care is delivered for members that require extensive on-going service. Development of the program utilizes but is not limited to, Apollo Guidelines, NCQA Guidelines, and Clinical Care Guidelines such as Institute for Clinical Improvement (ICSI), DHCS, CMS, Center of Excellence Guidelines and Preventative Health Guidelines (U.S. Preventative Services Task Force). This program will be focused on the delivery of cost-efficient, appropriate health care services for members with complex and chronic care needs.

- Case management works to use avai1able resources in the most effective manner;
- Case management coordinates Commercial, Medicare and Medi-Cal benefits, services for SNP members and effective 7/1/2019, coordination for CalOptima Medi-Cal members enrolled in the Whole Child Model [WCM].
- Case management seeks to eliminate waste, duplication, delays, and miscommunication to create an atmosphere where the medical plan can provide the optimal result; and,
- Case management utilizes a multi-disciplinary approach to management and coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and Long-Term Support Services.
- Case management annually assess the characteristics and needs of the group's assigned population and relevant subpopulation to update and address case management processes and resources to meet member needs.

II. GOALS AND OBJECTIVES:

Coordination of resources and creation of cost–effective alternatives for catastrophically, chronically ill, or injured members on a case-by-case basis to facilitate the achievement of realistic treatment goals.

Consider the member as a whole individual, taking into consideration not only his/her medica1 needs, but also the individual in the context of cultural values, age, disability, and self-determination.

Focus on members with the following characteristics:

- High recidivism;
- Medically complex;
- Chronically ill;
- Cost and/or length of stay outliers;
- Catastrophic diagnosis; and,
- Inadequate family/community support
- Long term care
- SNF short stay
- Member in the Whole Child Model Program
- Physical Disability
- Developmental Disability
- Severe Mental Illness

Will seek to accomplish the following:

- Coordinate care and cost-effective services.
- Monitor care that is easily accessible with no access barriers as related to member's available benefits.
- Apply benefits appropriately and coordinate with health plans.
- Promote early and intensive treatment in the least restrictive setting.
- Provide accurate and up-to-date information to providers regarding member evaluations.
- Provide member centric Case Management
- Provide Care Management for Whole Child Model members ensuring timely primary, preventive care and Specialty care.
- Provide minimum Basic Case Management services for every Medicare SNP member with involvement from PCP.
- Provide Catastrophic Case Management for identified.
- Create individualized treatment plans that are revised at a minimum annually and/or when a change in health care status is identified.
- Utilize multidisciplinary clinical, rehabilitative and support services.
- Arrange broad-spectrum appropriate resources for members.
- Deliver highly personalized case management services.
- Grant adequate attention to member satisfaction.
- Uphold strict rules of confidentiality.
- Provide on-going case management program analysis and development.
- Promote case management program's viability and accountability.
- Protect member rights and encourage member responsibility.

Maintain a strong link with other management functions, including, but not limited to, quality improvement, and utilization management.

Provide physician and staff education regarding the process to identify, refer and manage high-risk members within the IPA population. This includes but is not limited to education on the CalAIM Program, California Children's Services [in Los Angeles], and other State and Federal Programs where Case Management is performed by the agency or Health Plan.

III. POLICY

Equal importance is based on every aspect of the managed care process, from the verification of eligibility to the development of a comprehensive care plan that meets all of the member's medical and social needs as related to his/her illness. Mental Health needs will be assessed and referred or managed depending on the contracted coordination responsibility for mental health services of the members plan.

The program will be revised as frequently as necessary to comply with/or be accountable to changes within the department's scope and responsibilities.

IV. SCOPE:

The Case Management process will be directed at coordinating resources and creating cost–effective alternatives for catastrophically, chronically ill, or injured members on a case-by-case basis to facilitate the achievement of realistic treatment goals.

In order to maintain continuity of care, activities will be coordinated with Utilization Management, physicians, hospital case managers, members and families. Medicare, Duals Demonstration/Cal Medi Connect, SNP members and Whole Child Model members will also utilize an Interdisciplinary Team.

Case Managers (CM) will coordinate individual services for members whose needs include ongoing medical care, home health, hospice care, rehabilitation services, behavioral health, Home Community Based Services (HCBS), Long Term Support Services (LTSS) and preventive care services. Proactive clinical and administrative processes are implemented to identify, coordinate and evaluate appropriate high-quality services which may be delivered on an on-going basis.

Staff will have the appropriate licensure, education, and experience to meet membership requirements as identified in their assigned member population, including but not limited cultural competency training and understanding of the external resources available to meet member service needs for Case Management coordination. Staffing ratios may be adjusted due to the acuity levels identified. A clear description of the level of service each staff can perform will be listed in the employee job descriptions.

Case Management services will be provided to Special Needs Population (SNP), Seniors and Persons with Disabilities (SPD), Whole Child Model [WCM] and for all other health plan members where delegated. Nurse to active case ratio will consider acuity levels and be approximately 1:60 ratio.

The Manager of the Case Management Department will maintain ongoing monitoring of membership logs and ensure sufficient staffing to complete enrollee assessments, care coordination needs, care coordination oversight, monitor and review member grievances and organization and coverage determinations for the Cal MediConnect dual population.

The Medical Director and UM Committee is kept informed of all treatment planning that is coordinated by the Case Manager. The Case Manager will seek the direction of the Medical Director for difficult cases and issues that arise. Medicare PCP will be advised when catastrophic CM ends and Basic CM resumes.

All health plans do not delegate Case Management to the IPA. In some instances, the health plan assumes all responsibility and risk for this process.

Case Management will track all Carve Out Programs including specific agencies funded by the county, state or federal funded programs for members. This includes referral and coordination for services for Home and Community Based Services, Community Based Adult Services, Mental Health, Substance Abuse, School Based Programs, Early Start Programs, Direct Observed Therapy for Tuberculosis, Immunizations, Regional Centers, CCS and other Linked Program Services, as well as services eligible for disenrollment such as Long-Term Care, Major Organ Transplant, AIDS Waiver Program, etc.

Whole Child Model care coordination may include but is not limited to coordination of referrals, individualized care plans with input from Primary Care Physician, Specialty Care Providers and Interdisciplinary Care Team including not limited to, Parents/Caretaker, Health Plan, Regional Centers, High Risk Infant Follow up Program [HRIF], Medical Therapy Program [MTP], Medical Therapy Unit [MTU], EPSDT, including palliative care team, Home and community-based services and Inter-County Transfer representatives.

For members in the WCM, the Case Manager will evaluate all members approaching the age limitations for coverage and coordinate a transition plan with the member's PCP and specialty care providers. This may be established thru regular review of member eligibility data. This process will also include an evaluation of their current condition, treatment plan needs and evaluation of needs to transition to an adult provider. The Case Management will monitor for 3 years following age out.

Maintenance and Transportation [M&T] services for members in the Whole Child Model include but are not limited to transportation, meals, lodging and other necessary costs [i.e., parking, tolls, etc.] will be directed to, coordinated by and paid through CalOptima. In some cases, these services will be coordinated with the plan for out

of county and out of State service. For WCM members seeking services not related to their CCS eligible condition, transportation service will be coordinated and covered under their Medi-Cal benefit.

V. PROGRAM COMPONENTS

Referrals
Referrals for Case Management may come in form of written or verbal request from PCPs, specialists, and their support staff; the community, UM, QM or Health Education staff acute care and sub-acute care facilities and self referrals from members or families; review of inpatient census; retro-review of emergency room reports; UM statistics (those meeting high risk or catastrophic profile) Pharmacy statistics, claims and encounter data reports, results from an Initial Health Assessment and/or the Health Risk Assessment [HRA] evaluation for Medicare and/or the Health Needs Assessment [HNA] for Whole Child Model.

- In absence of an HRA or HNA, the Case Manager or Personal Care Coordinator will work in collaboration with the Health Plan, the member's assigned Primary Care Physician and the member to assist with the completion of the assessment.

All referral information received from Health Plans for coordination of care, [i.e. Health Information Questionnaire for Senior Members] will be reviewed by the Case Manager (CM) and triaged for Case Management Services.

Staff
Case management staff to perform case management and coordination of services and benefits could consist of the following: care manager, personal care coordinator, DME coordinator, UM review coordinator, discharge planning specialist, nurse manager, physician, or health information specialist.

Interdisciplinary Care Team (ICT)
The interdisciplinary care team works together to manage member care by analyzing and incorporating the results of the initial and annual HRA or HNA in the Care Plan, managing the medical, cognitive, psychosocial and functional needs of the member, conduct meetings or conference calls with plan, providers, and members and ICT members. E-mail, fax and written correspondence may be used to communicate with team members. Care coordination meetings will take place on a regular basis, at a minimum annually. The ICT will include the Member and Caregiver/family member or legal representative whenever possible. The Member may determine the level of participation of the caregiver and or family member. The ICT is led by professionally knowledgeable personal. The Member's Primary Care Physician (PCP) is usually the designated team lead and is credentialed. In addition the team includes at a minimum a Medical Expert, Social Worker/community resource specialist and Behavioral and/or Mental Health Specialist when mental health needs have been identified; and may also include but is not limited to: Registered Nurse, Physical/Occupational/Speech and/or Recreational Therapist, Board Certified Physician, Dietician/Nutritionist, Pharmacist/clinical Pharmacist, Nurse Educator, Preventive health/health promotion specialist, Pastoral Specialist, Discharge Planner, Long Term Support Services (LTSS) representation such as, Skilled Nursing Facility representative, IHSS social worker/coordinator, MSSP Coordinator, CBAS representative, Long Term Care provider and Personal Care Coordinator (PCC). In the case of a WCM member, representation may also include Parents/Caretaker, Health Plan, County CCS Health Care Manager, Regional Center Care Manager, High Risk Infant Follow up Program [HRIF], Medical Therapy Program [MTP], Medical Therapy Unit [MTU], EPSDT, including palliative care team, Home and community-based services and Inter-County Transfer representatives

Implementation

Referrals may be accepted verbally or on a written Case Management Referral Form.

The CM reviews the referral information. Urgent Referrals are triaged within 1 working day, Standard Referrals are triaged within 3 working days.

The CM opens a Case File and enters the member information in to the Case Management Log. An initial assessment form, to include a treatment plan, is completed (See P&P CM1). Both the member (or family if member is unable) and the primary care physician (PCP) must agree to the treatment plan. The member/caregiver is encouraged to take part in the care planning process.

Follow-up and/or Closure

Each case will be assigned an acuity level based upon the Case Management Level (CML) Screening Table. The acuity level of the case determines the amount of contact.

- Basic Case Management- no serious medical, behavioral or social issues, chronic conditions are well controlled or member's choice. Case management functions are managed by the PCP with minimum IPA interventions at key event or a minimum of every six months. Key events are tracked in the electronic medical record to determine if intervention intervals or case management level designation requires re-evaluation.

- Service Coordination- intermittent assistance required to facilitate an authorization request. Case management functions are managed by the IPA and contact is determined by the member's need. Case closure is evaluated when the issue has been resolved.

- Care Coordination- includes Care Transitions, medication therapy management, complex DME or authorization issues. Case management functions are managed by the IPA with minimum of monthly interventions or as determined by the member's need. Case closure is evaluated when the goals are met.

- Complex Case Management- decompensation of a chronic condition, diagnosis requiring multiple modalities, end of life care, transplant, or if the level of CM intervention is at such a level requiring intense and frequent interactions. Case management functions are managed by the IPA with minimum of monthly interventions or as determined by the member's need. Case closure is evaluated when the goals are met.

Member Choice is documented, scheduled and adhered. For the Whole Child Model, this will include choices of Parent/Caretaker or legal representative.

The CM nurse will facilitate communication between members, their families, health care providers and the health plan in an effort to enhance cooperation while planning for and meeting the member's healthcare needs.

Case Managers will conduct re-assessments as the health status, functional status and social need of a member requires and at least annually. Reasons for re-assessment needs will be documented including the member's preference when determining the mode by which updates will be completed.

Case Management files are closed when the member is no longer eligible, has reached treatment goals, refuses to participate in case management, or expires. Members with closed cases may be screened for re-entry at any time. If a criterion is met, the case will be re-opened with Active status. When goals are met for Complex Medicare cases, the case will be transitioned to the PCP for Basic Case Management services.

All cases in Active status are discussed on a regular basis with the Medical Director and are presented for discussion at the Utilization Committee Meeting.

VI. EVALUATION

A monthly summary of all Case Management activity will be presented to the UM Committee. The UM Committee may recommend further needs for intervention to the Case Manager.

Members who participate in Case Management Services will be chosen for a direct mailing of the IPAs Annual Member Satisfaction Survey and/or a verbal "exit survey" may be performed at time of closure of case. The survey will include questions relating to satisfaction with Case Management services. The Case Management section will be summarized separately and reported back to the UM Committee.

The Quality Improvement Program includes members from the Case Management Program in assessing three measures to identify opportunities for improvement. Goals will be set, and measurement will be performed. This information will be presented to the QI Committee who will assess findings and plan for interventions. After interventions are completed, re-measurement will take place. This information will be reported through the Quality Management Work Plan quarterly reporting to the UM/QI Committees.

In addition, as part of the Annual Evaluation of the Case Management program, will include but is not limited to:

- Annual population assessment
- Annual review of evidence-based Case Management Criteria
- Staffing assessment including but not limited to, educational assessment, cultural competency, community resource updates, benefit changes

The Annual Evaluation will be reported back to the UM/QI Committees for additional recommendations for program improvement. This information may be included in the group's annual work plan.

VII. CONFIDENTIALITY

All staff participating in Case Management activities shall be required to sign a confidentiality agreement that is updated annually. The agreement will be maintained in the employee's file.

SUBJECT: Case Management of Transplants **Policy #:** CM3
DEPARTMENT: Quality Management

Effective Date: February 2005
Last Revision Date: October 8, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define the guidelines for coordination of care by IPA and a contracted health plan, when defined by contract between IPA and Health Plan, for those members that have been identified as organ/bone marrow transplant candidates.

Effective 7/1/2019, transplant services for CalOptima Medi-Cal members under the age of 21 will be covered by the Whole Child Model Program if the transplant is performed in a Centers for Medicare & Medicaid Services (CMS) approved, Department of Health Care Services (DHCS) approved Transplant Center or DHCS-approved Special Care Center (SCC) for that specific transplant.

POLICY:

Transplants will be a covered benefit under the Medi-Cal Managed Care Program when determined by a Center of Excellence and the member's Health Plan that the recipient meets the patient selection criteria.

Medical and hospital expenses that are directly related to the organ procurement process for a recipient will be covered as per the IPA's contract with the plan. Donor expenses are covered services to the extent that the donor is not covered by any other medical insurance, as per the IPA's contract with the plan.

IPA will coordinate with California Children Services (CCS) on transplant procedures for all eligible transplant procedures on recipients who are CCS-eligible.

FOR MEDI-CAL: The transplant and related services will be covered when the Transplant is performed in a Center of Excellence, Medi-Cal facility that is approved by DHS for that specific Transplant and when the Recipient meets the patient selection criteria for the following Transplants:

- Heart
- Heart/Lung
- Lung
- Bone Marrow
- Liver
- Small Bowel
- Kidney
- Combined Liver and Kidney
- Combined Liver and Small Bowel
- Combined Kidney and Pancreas

Effective 7/1/2019, transplant services for CalOptima Medi-Cal members under the age of 21 will be covered by the Whole Child Model Program upon determination that the member is a transplant candidate, is compliant with all requirements and does not have significant contraindications for the transplant. The Health Network is responsible for Care Coordination and all other medical services until the member is determined to be a transplant candidate. Once the member is **determined** to be a transplant candidate, CalOptima will coordinate transfer to its CalOptima Care Network [CCN]. CalOptima is then responsible for the provision of all services related to the Transplant including but not limited to, evaluation of potential donors and procurement from living or deceased donors. The Health Network will notify the Health Plan upon identification of a member who is listed for a Solid Organ Transplant at a DHCS approved Transplant Center or a designated Special Care Center or is approved for BMT. If a Health Network member including a Whole Child Model (WCM) member, is identified as a potential candidate for BMT or a Solid Organ Transplant, the Health Network shall provide Case Management for all other Covered Services including, but not limited to, management of ventricular Assistive Device (VAD) procedures, Dialysis and Transjugular Intrahepatic Porsystemic Shunt (TIPS) procedures.

For all other major organ transplants for Medi-Cal members, the member's plan initiate disenrollment confirming the Referral of the Member to the organ transplant Facility, the Facility's evaluation has concurred that the Member is a candidate for major organ transplant; and the major organ transplant is authorized by either DHCS's Medi-Cal field Office (for adults) or the California Children Services Program (for children). Upon the disenrollment effective date, the PCP shall ensure continuity of care by transferring all records to the transplant physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the Member was approved as a major organ transplant candidate. If the Member is evaluated and determined not to be a candidate for a major organ transplant or DHCS denies authorization for a transplant, the Member will not be disenrolled.

The PCP shall continue to provide all medically necessary covered services during the transplant evaluation process.

IPA will provide case management to all members identified as transplant candidates and assist with the coordination of care throughout the transplant process and coordinate with the member's health plan as indicated.

DEFINITIONS:

Administrative Hold: The time when a transplant case is placed on pending status awaiting resolution of administrative issues.

Case Management: A systematic approach to coordination of care for patients with special needs and or complex medical conditions that includes the elements of assessments, care planning, interventions, monitoring, and documentation.

Center of Excellence (COE): Facilities that are approved by CMS and/or DHCS to provide specific transplant services.

Donor: An individual who undergoes a surgical operation for the purpose of donating a body organ, human tissue, or cells for transplant.

Special Care Center (SCC): is a CCS-approved Transplant Center for Bone Marrow, Heart, Lung, or Kidney Transplants is a Special Care Center that provides comprehensive, coordinated health care for CCS members with specific medical condition, meets standards established by DHCS and is approved by DHCS to participate in the CCS Program.

Transplant: A non-experimental procedure for human tissue and/or organ transfer from one human being to another.

PROCEDURE:

A. Patients will be screened for potential transplant status by case management, through referrals by physicians, performance of routine ambulatory and inpatient review; referral by other departments, (i.e. QI, Member Services, Claims, Provider Services); or diagnosis driven reports.

B. If identification is made by a method other than physician referral, case management will confer with member's PCP to assure that a referral is appropriate.

C. Authorization will be provided for a transplant screening evaluation at the Center of Excellence (COE) or CCS-approved Special Care Center within UM guidelines: 24 hours for urgent requests, two (2) working days for routine requests of the Primary Care Provider (PCP) or Specialist identifying the member as a potential candidate for the MOT services and receiving all of the necessary information to make a referral or authorization as appropriate in accordance with DHCS All Plan Letter (APL) 21-015.

D. The IPA Case manager will notify the appropriate health plan's case manager of the member's "potential transplant status" within 1 day of member identification.

E. A case management file will be opened by the IPA Case Manager.

F. Case management will place an introductory call to the member within five (5) working days of opening the case. The members will be notified of the COE or SCC for which they are being referred.

G. The health plan will be responsible for mailing a Transplant informational packet to the member and contacting the member to ensure receipt of the information and to answer any questions.

H. IPA case management will provide a global authorization to the COE so that a comprehensive and complete transplant work-up may be performed to determine medical suitability, including candidacy and compliance, so that the member may be placed on the Transplant list.

    1. The work-up will be completed within 45 days of the evaluation start date.

    2. To ensure continued reimbursement of Transplant related claims, the IPA case management department must obtain extension approval from the health plan for evaluations that are not completed within 45 days.

I. Follow-up

1. IPA case management shall follow up with the member on a weekly basis to identify any issues that may prevent the member from completing the COE evaluation and work-up.

2. If the evaluation cannot be completed within 45 days, the COE will notify and coordinate with the IPA case management department.

3. Failure to complete an evaluation within 45 days after evaluation start date may result in:

    a. Health plan approval of an extension based upon clinical justification; or

    b. Administrative Hold, until an adequate evaluation is completed; or

    c. Further action, as identified by the health plan, for non-compliance.

J. After opening a Transplant case, the IPA case management department will complete an initial assessment and care plan. The assessment and care plan will be updated as the member's status changes.

K. The IPA case management department will notify the health plan case manager of any significant changes in the member's status.

L. Once the member is placed on the transplant list, the Case Manager will monitor the member's eligibility and coordinate any transfer of records should the member no longer remain eligible.

<u>For Anthem Blue Cross</u>:

In addition to the appropriate procedures above, the Case Manager, Concurrent Review and UM Referral Coordinators will coordinate with the plan to:

1. Notify the plan within 1 day of potential transplants to verify plan's approved Center of Excellence to be utilized and open case for ongoing coordination/communication with the plan.
2. Informational letter to members and practitioner must be issued immediately when sending the experimental/investigational referral to Anthem.
3. Issue the pend/deferral letter if clinical information is missing.
4. Advise members regarding utilization of BCC Centers of Medical Excellence.
5. Issuing denial letters for benefit limitation, out-of-network providers, lack of medical necessity case after medical review (not investigation/experimental)
6. Where delegated, will coordinate notifications of approvals for the actual transplant and the transplant admission following receipt of the health plan's approval information.
7. Provide referrals and authorizations for all pre- and post-transplant services.
8. Documentation of concurrent review, discharge planning, case management member needs.
    a. In addition, they will notify the plan Case Manager within 2 business days of any transplant related admission. Depending upon delegation, the plan may already be monitoring the admission and notification would be coordinated within Anthem Blue Cross.
9. Work with Provider Services/Contracting to negotiate fee arrangements for the professional component of the transplant if a non-participating Transplant Center is required.
10. Coordinate with Anthem's Case Manager any issues requiring assistance.

SUBJECT: Interdisciplinary Care Team **Policy #:** CM5

DEPARTMENT: Quality Management

Effective Date: June 2, 2010
Last Revision Date: June 20th 2026
Last Review: June 2026

SCOPE: This policy applies to Medicare Special Need Plan SNP members CalOptima Seniors and Persons with Disability [SPD] members and effective July 1, 2019, CalOptima Medi-Cal members enrolled in the Whole Child Program.

PURPOSE:
To define the role of the Interdisciplinary Care Team (ICT).

POLICY:

A Program will be established to ensure that all beneficiaries receive at a minimum a basic care plan or complex care plan that is reviewed at least annually by an Interdisciplinary Care Team [ICT] or as often as the health status, functional status or social needs of the member requires, or recommendations from MTM [Medical Therapy Management].

An ICT will be offered to coordinate the delivery of services and benefits to every enrollee when a need is determined or one is requested and is in accordance with the members functional needs as assessed in the care plan and integrates medical, behavioral health and Long Term Support and Service (LTSS) needs identified including but not limited to In Home Supportive Services (IHSS) **)** including providing education on the member's right to self-direct, hire, fire, and manage the IHSS provider, Multi-purpose Senior Service Program (MSSP), Community Based Adult Services (CBAS) and Skill Nursing Care services

The Care Team ICT will include the Member and Caregiver/family member or legal representative whenever possible. The Member may determine the level of participation of the caregiver and/or family member. The ICT is led by professionally knowledgeable personnel. The Member's Primary Care Physician (PCP) is usually the designated team lead and is credentialed. In addition the team includes at a minimum a Medical Expert, Social Worker/community resource specialist and Behavioral and/or Mental Health Specialist when mental health needs have been identified; and may also include but is not limited to: Registered Nurse, Physical/Occupational/Speech and/or Recreational Therapist, Board Certified Physician, Dietician/Nutritionist, Pharmacist/clinical Pharmacist, Nurse Educator, Preventive health/health promotion specialist, Pastoral Specialist, Discharge Planner, Long Term Support Services (LTSS) representation such as, Skilled Nursing Facility representative, IHSS social worker/coordinator, MSSP Coordinator, CBAS representative, Long Term Care provider and Personal Care Coordinator (PCC). In the case of a WCM member, representation may also include Parents/Caretaker, Health Plan, County CCS Health Care Manager, Regional Center Care Manager, High Risk Infant Follow up Program [HRIF], Medical Therapy Program [MTP], Medical Therapy Unit [MTU] EPSDT, including palliative care, Home and community-based services and Inter-County Transfer representatives.

The goals of the Interdisciplinary Care Team are to:

- Develop and implement an individualized care plan with member and/or caregiver participation.
- Authorize and/or facilitate access to specialists and therapies.
- Advocate, inform and educate members on services and benefits.

- Manage care and pharmacotherapy.
- Coordinate care across settings and providers
- Conduct chart reviews.
- Identify and facilitate access to community resources and social services.
- Monitor provision of services and benefits to ensure follow up.
- Conduct a medication review.
- Ensure timely claims.
- Assure compliance with CMS statutory and regulatory requirements.
- Triage member's care needs.
- Review and analyze utilization data.

Additional duties will include, but are not limited to:

- Conduct performance assessments.
- Develop a process to assess, monitor and/or observe Interdisciplinary Team meetings and effectiveness of Program.
- Monitor and review member grievances

A call line or other mechanism(s) to facilitate conference calls among the team and for members and/or their legal representative for inquiries and input as well as other referring agencies, such as LTSS, behavioral health agency, etc. as appropriate.

For Medi-Cal, Medicare and SNP programs, the member's approval of the family or caregiver participants in the ICT will be maintained on file. This approval may be clearly documented in writing from the member or his/legal representative or from a verbal conversation with the member or his/her legal representative. Consideration is given to the member's individual needs, communication barriers and cognitive needs when communicating with the member. Communication may occur via secure email, fax, web portals and written correspondence to members. Meetings will occur periodically and at the member's discretion.

A Nurse Case Manager and a Personal Care Coordinator (PCC) are assigned to each member. The ICT will work collaboratively to act as a gatekeeper and ensure timely and appropriate referrals within the contracted provider network. If services are required outside the provider network, the Interdisciplinary Care Team will be notified. All referral activity is tracked and commented upon in the members Case Management files. Results from tests and consultation notes will also be kept in the Case Management file. The PCC will assist members where required with obtaining appointments and any transportation needs. Failed appointments are documented by the Primary Care Physician's office and a call will be made to assess the reason for the failed appointment and intervene where possible.

The Care Management Staff will include but is not limited to:

- Case Manager
- Personal Care Coordinator (PCC) with the appropriate experience and qualifications based on the acuity level assigned to the case and member's individual need when need is identified or at the member's request.
- Durable Medical Equipment Coordinator
- Utilization Review Coordinator
- Discharge Planning Specialist
- Nurse Manager or Coordinator
- Health Information Specialist

Administrative and Clinical oversight staff will include, but is not limited to:

- Medical Director

- Administrator, Director, Executive Staff
- Care Coordinator

The IPA will ensure availability of a full network of providers and facilities with clinical expertise pertinent to the targeted needs of the population beyond the scope of the Interdisciplinary Care Team.
The Credentialing department conducts the monthly License, DEA, and Malpractice expirable process to ensure that established contracted physicians are checked and monitored to maintain current and updated licenses and documentation. This process ensures patient safety and adheres to state and federal regulations. The Credentialing department will outreach to providers at the 90/60/30-day marks to communicate license expirations and obtain updated documentation. The list of providers whose licenses are set to expire will be compared against our current approved IPA contracted providers to ensure that the physician(s) have not termed and ensure system integrity.

Ancillary Services may include but are not limited to, outpatient hospital services, urgent and emergent care, home health services including risk assessments such as home safety evaluations, fall prevention, wellness programs, pharmacy review, palliative, and end of life care, etc.

The Specialists' responsibility will include but is not limited to assessing, diagnosing, treating, and conferencing with the Interdisciplinary Care Team and assisting with the Individualized Care Plans [ICPs].

The Medicare SNP are responsible for performing Health Risk Assessments [HRAs] for the members. These HRAs will be forwarded from the health plan to the IPAs with an acuity rating. The Case Managers will retrieve and review HRAs received from the plan daily. HRAs may be posted to the group FTP site or retrieved from a plan portal depending upon each individual plan's process for forwarding information. The information identified on the HRA will be used to develop an ICP for each member using evidence-based clinical guidelines or algorithms to conduct assessment and management.

Members with a Low Acuity rating may be managed through a Basic Care Plan process. All members with a Moderate and/or High Acuity Rating will be assessed by a Case Manager for Complex Case Management intervention. Members with Moderate or High Risk non-catastrophic risk, who refuse Case Manager assistance, may be managed by the PCP. The PCPs Basic Care Plan will include review of the Health Plan's Health Risk Assessment, the Member's Medical History, Member's health care preferences, and initial assessments.

All members have the right to accept and/or refuse Case Management. Members will not be disenrolled for lack of participation in Case Management or the ICT. For members with a Moderate or High Acuity rating, if the member refuses Case Management intervention, they must have a minimum of a Basic Care Plan on file.

For members accepting Complex Case Management intervention, an Individualized Care Plan [ICP] will be created by the Case Manager using evidence-based clinical guidelines or algorithms to conduct assessment and management.

The ICP Assessment can be made face-to-face, telephonically or through written correspondence. Providers may coordinate through a Web-based program when available. The ICPs will be monitored and updated at key events and at a minimum every six months or as often as the health functional or social needs of the member requires or when there is a change in the member's health status and care planning will occur as needed without a set schedule. The member's preference is documented and adhered to as well.

ICPs will include an assessment of the following:
- Health status, including condition specific issues.
- Clinical history, including medication history.
- Activities of daily living.
- Behavioral health status including cognitive functioning.
- Psychosocial issues.

- Life Planning activities.
- Cultural & Linguistics needs, preferences, and limitations.
- Visual and hearing needs, preferences, and limitations.
- Caregiver resources and involvement.
- Discussion of plan benefits and member's health care preferences
- Add on services, i.e., dental, vision/refraction services, respite and/or community resources, other health plan coverage will be analyzed.
- Setting realistic member or caregiver prioritized goals and discussion regarding barriers to goals, preferences and level of member or caregiver's participation in the care plan with ultimate goal of self management
- Schedule of communication and follow up with members and/or caregivers.
- Monitoring and documentation of the progress against the case management plan

The Case Manager and PCP will work collaboratively to avoid unplanned transitions of care by coordinating services for members at high risk for hospitalization and educating members on self management of their disease and regarding use of Emergency Room and/or Urgent Care services.

The Interdisciplinary Care Team (ICT) has access to review claims and UM data. Routine review of these areas is done to ensure that ER, Acute and SNF admissions and discharge planning is incorporated into the care planning process. For Behavioral Health admissions, which are not a delegated function, the Case Managers will ensure that Behavior Health admissions are identified by coordinating care with the delegated party and updating care planning process to reflect partnership with the delegated parties. The Case Manager and PCC set 'Alerts' within the member's record to inform staff to notify the Case Manager of any activity.

ICPs and Basic Care Plans will be reviewed at least annually by the Interdisciplinary Care Team or as often as the member's health and social status requires. This may occur through a regularly scheduled Care Coordination Meeting, UM Committee Meeting, Conference Call, Written Correspondence, Confidential secure e-mailings and/or faxes, person to person direct interface or web-based team networking or through review of on-line shared electronic information for team meetings without a set schedule. These meetings will be documented in the form of minutes and/or Care Plan Case Management notes, which will list attendees including team members, members and caregivers that may be present. Attendance will be taken and a minimum of 3 care team representatives will be present.

All PCPs, Specialists and MSO employees and any contracted Social Worker coordinating care for members will receive initial, ongoing, and annual refresher when required by plan, education regarding and the Model of Care and Dementia Care for designated care coordination staff. Sign in sheets from in-services, classes, etc., will be maintained on file were performed on site. Training may occur via face-to-face training, web-based interactive training, or self-study program [review of printed materials or electronic media]. For attendance at a Health Plan's training session, the plan will maintain copies of the sign in sheets.

The Medical Group's QI Committee is responsible for assessing policy changes, ensuring adequate staffing, ensure adequate provider network, and reporting the results internally and externally.

Members are informed of their right to file a formal complaint.

Annually a survey will be conducted to assess satisfaction with the Care Management services. The QI Committee is responsible for intervening and ensuring any identified deficiencies are addressed and corrected. Once cases are closed, members will be surveyed regarding their satisfaction with the Care Management process. Members, or their Caregiver, who participate in the Interdisciplinary Care Team meetings will be surveyed upon departure from the program.

The Medical Group will submit data to the Health Plan and/or CMS as requested.
When a member participating in Case Management with an ICP and ICT is no longer eligible and/or transitions to another plan [or county as in the WCM], ICP and ICT data will be shared with the receiving entity according to plan policy. In some cases, the plan may require the information to be sent directly to the plan and the plan will coordinate with the new provider.

DEFINITIONS:

Basic Care Plan**:** A set of information about the member that facilitates communication, collaboration, and continuity of care across settings. The plan contains but is not limited to medication regimen, allergies, advance directives, baseline physical and cognitive functioning support system and contact information for member's professional care providers and informal care providers. The plan is based on member assessments and is reviewed and revised annually or more frequently if a member's health status changes.

Individual Care Plan [ICP]: A plan of care developed after an assessment of the member's social and health care needs that reflects the member's resources, understanding of his/her disease process, and lifestyle choices.

Interdisciplinary Care Team [ICT]: A team comprised of a medical expert, mental health/behavioral health expert, social service/community resources expert, and/or other professional disciplines as appropriate.

Special Need Plan [SNP]: A program of health care, services, and management for members that are dually eligible for Medicare and Medicaid benefits and services or institutionalized or institutional equivalent residing in the community or having certain CMS-approved severe or disabling chronic conditions.

PROCEDURE:

1. Upon receipt of the HRAs from the plan, each HRA will be scanned into the Case Management Program. HRAs will be faxed/mailed to PCP.

2. All Basic Care Plans received from the PCP will be scanned in and reviewed annually by the Interdisciplinary Care Team.

3. All members with a Basic Care Plan Requesting Case Management intervention will be triaged further, and the Case Manager will create an ICP and follow the process according to the CM1 & CM2.

4. All members with HRAs resulting in Moderate and/or High Risk will be triaged by the Case Manager according to CM1 & CM2.

5. At a minimum annually, or as often as the members health status, functional status and social needs require, the ICT will review and intervene with the Care Plan.

6. Members of the ICT will receive notice and/or alert of changes to member status or emergency/urgent care visits and/or hospital admission.

7. The team will be initially educated on the person-centered care planning process, cultural competency, accessibility and accommodations, independent living and recovery and wellness principles, Long Term Support and Services and eligibility for these services and program limitations. Annual re-education will be provided to all staff involved in the ICT process.

8. In the case of the WCM program where an intercounty transfer occurs, coordination will occur directly with CalOptima and will I include but is not limited to a copy of the most recent ICP, clinical and relevant data including any admissions, open authorizations for last 6 months and most recent HNA.

FORMS:
Basic Care Plan

SUBJECT: Transitions of Care for Medicare Members **Policy #:** CM6

DEPARTMENT: Case Management

Effective Date: June 22, 2010
Last Revision Date: June 19th 2026
Last Review: June 2026

SCOPE: This policy applies to Medicare SNP.

PURPOSE: The IPA takes steps to coordinate aspects of transitions to avoid potential adverse outcomes. It may do so either by conducting the activities itself, by monitoring providers & practitioners who complete the activities or by working together with providers & practitioners.

POLICY:

The IPA will make a special effort to coordinate care when members move from one setting to another such as transitions from a member's usual setting of care to the hospital and when they are discharged from a hospital to next setting. This includes but is not limited to transitions from home to acute care, from acute care to nursing facility and/or sub-acute facility and to home or other setting.

Transitions are considered in the pre- and post-discharge planning process.

The IPA will identify transitions of their members by reviewing reports of hospital admissions and admissions to long-term care facilities within one business day of admission or within one business day of admission notification.

The Case Manager/Care Coordinator will identify any barriers to transitions and work to minimize unnecessary complications related to care setting transitions to reduce any potential hospital readmissions. This includes but is not limited to facilitation of Leave of Absence and bed holds for member currently residing in skilled facility and will be returning to the same location for continuity of care needs. The Case Manager will ensure all community supports, including housing are in place prior to member movement and that all Providers are fully knowledgeable and prepared to ensure support of member throughout the transition, including but not limited notice to other care team members and care coordinators on behalf of the member such as the members assigned Long Term Support Services coordinator. Transition of Care plans will also take into consideration all environmental adaptations, the member's equipment and/or technology needs.

The Medicare SNP Health Plan is responsible for performing Health Risk Assessments [HRAs] for the members. These HRAs will be forwarded from the health plan to the IPAs with an acuity rating. The Case Managers will retrieve and review HRAs received from the plan daily. HRAs may be posted to the group FTP site or retrieved from a plan portal depending upon each individual plan's process for forwarding information. The information identified on the HRA will be used to develop an ICP for each member using evidence-based clinical guidelines or algorithms to conduct assessment and management. If there is no HRA received at the time of TOC outreach, the Case manager will educate the member and warm transfer to the health plan to complete the HRA.

The Case Manager/Care Coordinator will facilitate the transfer and communication of the member's ICP between the sending setting and receiving setting within 1 business day of notification that a transition has occurred.

Transition consideration will also be given to Hospice at the member's home when requested, home-based community setting, Long Term care facility needs, mental health placement needs and transition to the home for post-acute admissions.

The IPA will minimize unplanned transitions and works to maintain members in the least restrictive setting possible.

Data will be analyzed at least monthly to identify individual members at risk of transition. Data will include but is not limited to review of authorization history, emergency/urgent care use, to assess potential for transition and implement at least one intervention for potential prevention.

DEFINITIONS:

Transition: Movement of a member from one care setting to another as the member's health status changes: for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving form the hospital to a rehabilitation facility after surgery.

Transition Process: The period from identifying a member who is at risk for a care transition through the completion of a transition. This process goes beyond the actual movement from one setting to another; it includes planning and preparation for transitions and the follow-up care after transitions are completed.

PROCEDURE:

A. Planned and unplanned transitions are identified on the IPA concurrent review log. This log is reviewed daily by a Case Manager/Care Coordinator.

B. For planned or unplanned transitions, sharing of the member's current Care Plan on file is done within one business day by Hospitalist to Attending Physician or Case Manager to Case Manager or Discharge Planner.

C. Communication with the member or responsible party about changes to the member's health status and plan of care will occur within 1 business day.

D. The member's PCP will be notified of the member's planned and unplanned transition by faxing the notification or member's facility face sheet to the PCP within 1 business day.

E. The member's ICP is updated based on the changes of health care status reported and the member's current change in needs, where identified.

F. The updated ICP is sent via fax or electronically via secure email to the Member's PCP and the ICT participants. The member care plan is mailed to the member or Member's representative.

G. The Case Manager/Care Coordinator will contact the member and inform the member they are the point of contact to ensure scheduling of an outpatient appointment and/or conducting follow-up with the patient and or caregiver. Appointments with Primary Care Physician or Specialist should occur no later than 5 days

post discharge or within timeframe defined by the discharging physician. The post discharge medication reconciliation will be conducted during this outreach with the member. The Case manager will review the post discharge medication list and educate the member to ensure medications are taken as instructed.

If the member is Unable to Contact (UTR) the Case Manager/Care Coordinator will make 3 attempts on different days and at different times to reach the member. If the member is still (UTR) after the 3rd attempt, a letter will be mailed to member. If a member's phone access is interrupted, the Case Manager may send a letter to the member requesting the member to contact their Case Manager or PCC to update contact information or other alternative methods to obtain a valid number will be used such as outreach to the Primary Care physician or health plan.

H.

UTR cases will be closed 14 days after mailing the UTR letter.

I. For all transitions, the IPA will conduct an analysis of the aggregate performance on the above aspects of managing transitions.

J. Upon receipt, Case Manager reviews the Health Risk Assessments of SNP members to identify members that may be at risk of transition. Identified at risk members will be evaluated monthly for case management needs which includes coordination of services. The member's PCP may be designated as the Case Manager by member choice or member's low, moderate, or high (non-catastrophic) risk score.

K. If there is no HRA received at the time of TOC outreach, the Case manager will educate the member and warm transfer to the health plan to complete the HRA.

L.

M. In addition to review upon Admissions, ER data and reports of un-used Prior Authorizations are reviewed for identification of possible risk of transition at a minimum annually.

N. The PCP and the Case Manager educate at-risk members or responsible parties about maintaining health and remaining in the least restrictive setting as part of the CM process. This education can also take place at the post-hospital follow-up visit.

Transition of care (TOC) cases will remain open until all care needs are met, or until members request no further follow-up or 14 days after the UTR letter with no response.

FORMS:
Not applicable

REFERENCES:
2014 NCQA SNP S&P Measures

SUBJECT: Coordination of Medicare and Medicaid Coverage **Policy #:** CM 7

DEPARTMENT: Case Management

Effective Date: June 22, 2010
Last Revision Date: February 2015
Last Review: January 2024

SCOPE: This policy applies to the Medicare SNP Program.

PURPOSE: The identify steps to coordinate Medicare and Medicaid benefits and services for members.

POLICY:

The IPA helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers.

PROCEDURE:

A. The Health Plan provides prospective members with information about the benefits they are eligible to receive from both programs.

B. The PCP and/or Case Manager review the member's benefits with the member/caregiver while preparing the Individual Care Plan.

C. The PCP, CM and Member Services are available to answer questions regarding the member's benefits under Medicare and Medicaid.

D. Members are given a clear, written explanation of their rights to pursue grievances and appeals under Medicare Advantage and under the state Medicaid program whenever services are denied or modified.

FORMS:
Not applicable

REFERENCES:
2014 NCQA SNP S&P Measures

Orange County Physicians IPA Medical Group, Inc. dba
NOBLE
Community Medical Associates, Inc. of Mid Orange County

2023 SPECIAL NEEDS PROGRAM [SNP] CARE MANAGEMENT

GOAL:

To establish a program to ensure that medically necessary care is delivered for Special Needs Population [SNP] members that require extensive on-going service. This program will be focused on the delivery of cost-efficient, appropriate health care services for SNP members with complex and chronic care needs.

The characteristics and needs of the group's assigned population and relevant subpopulation are annually assessed to update and address case management processes, verify the most vulnerable population and resources needed to meet member needs and goals to ensure a full network of providers and facilities with clinical expertise pertinent to the targeted needs of the SNP population beyond the scope of the Interdisciplinary Care Team.

Case management utilizes a multi-disciplinary approach to management and coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and Long Term Support Services.

POLICY:

Members will be identified for SNP Case Management services by the following avenues:

1. Monthly review of Eligibility reports
2. Health Plan Health Risk Assessments [HRA]
3. Health Plan notice of prior Case Management case and/or for co-coordination which may include but is limited to historic data of UM, CM Assessments, IHSS, MSSP, SNF, BH and Pharmacy information.

All members have the right to accept and/or refuse Case Management. For members with a Moderate or High Acuity rating, if the member refuses Case Management intervention, they must have a minimum of a Basic Care Plan on file. When a member refuses to participate in the Case Management process, data will be obtained from available medical records, providers, UM and Claims sources. Members also have the right to approve or disapprove of the authorized representatives who may be involved in the Interdisciplinary Care Team (ICT).

All members will be educated on the roles and responsibilities of each participant who will support them through transitions of care from their Primary Care Physician, to the introduction of their assigned Case Manager and Personal Care Coordinator [PCC]. Information is shared during the introductory phone call. The introductory phone call will provide the member/care giver information on how to obtain personal health information, share information with care team members, role of the members on the team including but not limited to advocacy, coordination of care, transition of care concerns, preferred mode of communication and level of participation desired by the member/caregiver. In addition, members will be educated on the benefits and services covered by their plan and available community resources. Communication may be written when verbal means are not available.

Members will receive a timely and thorough initial and annual assessment of their medical needs and social issues impacting the delivery of medical care. These assessments will be based upon, but not limited to, the following elements:

- Member's health care status, including condition-specific issues and co-morbidities;
- Documentation of Clinical history, including medications and adherence ;
- Initial assessment of activities of daily living;
- Initial assessment of behavioral health status, including cognitive function;
- Initial assessment of psychosocial issues;
- Initial assessment of life-planning activities;
- Evaluation of cultural needs, preferences or limitations
- Evaluation of visual and hearing needs, preferences or limitations
- Evaluation of fall risk status
- Evaluation of preventive care services
- Evaluation of environmental factors
- Evaluation of living conditions
- Evaluation of medication adherence
- Evaluation of caregiver resources or involvement
- Evaluation of benefits within plan or community resources
- Development of Individualized Case Management Plan, including prioritized goals, consideration of member and caregivers goals, preferences and desired level of involvement in the care plan;
- Development of goals in the form of specific, measureable, achievable, results-orientated and time bound structure (SMART);
- Indication of barriers to meeting goals or complying with care plan;
- Identification of appropriate providers and facilities such as medical rehab, and support services to meet Member care needs
- Facilitation of need for services/referrals/resources and follow up process to determine members act on referrals
- Development of a schedule for follow up and communication with member and/or caregiver
- Development, education and communication of member self-management plan
- Prognosis and process to assess progress against case management plans for members.
- Member preferences, strength and capacity and choices regarding treatments, services and abilities
- Annual assessment of characteristics of individuals with disabilities and/or serious and persistent mental illness

Based on the individual needs of the member, HRA received from the Plan or retrieved from the plan's provider portal and findings in the Initial Assessment, and annually thereafter, the participants in the member's Interdisciplinary Team [ICT] are identified. ICT participants are selected to participate based on their expertise relating to the subject of the member's specific healthcare needs to make meaningful contributions to the development and implementation of the Individualized Care Plan and to improve the member's health status throughout the continuum of care. At any change in the member's health status, additional participants may be added to address any new specific needs.

All PCPs, Specialists and MSO employees and any contracted Social Worker coordinating care for members will receive initial, ongoing and annual refresher education for the health plan specific Model of Care. Sign in sheets from in-services, classes, etc., will be maintained on file where performed on site. Trainings may occur via face-to-face training, web-based interactive training or self-study program [review of printed materials or electronic media]. For attendance at a Health Plan's training session, the plan will maintain copies of the sign in sheets.

Model of Care training is mandatory and participation is monitored and documented. Challenges can occur with timely completion by PCPs, Specialists and or MSO employees. To overcome a delay in timely completion, communications are sent out in advance of the due date. Incremental reminders are sent out regarding the approaching due date and may include one to one, face to face or written communication to support timely completion. When PCPs, Specialists and or MSO employees have been identified as delinquent in completing the training, notification is made verbally or in writing to address the completion requirement. Those who fail to complete the training will be reported to the Quality Management for intervention and possibly disciplinary action.

The Care Team ICT will include the Member and Caregiver/family member or legal representative whenever possible. The Member may determine the level of participation of the caregiver and or family member. The ICT is led by professionally knowledgeable personal. The Member's Primary Care Physician (PCP) is usually the designated team lead and is credentialed. In addition the team includes at a minimum a Medical Expert, Social Worker/community resource specialist and Behavioral and/or Mental Health Specialist when mental health needs have been identified; and may also include but is not limited to: Registered Nurse, Physical/Occupational/Speech and/or Recreational Therapist, Board Certified Physician, Dietician/Nutritionist, Pharmacist/clinical Pharmacist, Nurse Educator, Preventive health/health promotion specialist, Pastoral Specialist, Discharge Planner, Long Term Support Services (LTSS) representation such as, Skilled Nursing Facility representative, IHSS social worker/coordinator, MSSP Coordinator, CBAS representative, Long Term Care provider and Personal Care Coordinator (PCC).

The goals of the Interdisciplinary Care Team are to:

- Authorize and/or facilitate access to specialists and therapies;
- Advocate, inform and educate members and/or their designated representative on services and benefits;
- Manage care and pharmacotherapy;
- Identify key staff and or PCP responsible to coordinate care across settings and educate members/care givers and providers of that key staff/PCP.
- Conduct chart reviews to ensure the appropriate use of clinical practice guidelines and nationally recognized protocols for preventive and chronic care needs;
- Identify and facilitate access to community resources and social services;
- Monitor provision of services and benefits to ensure follow up;
- Conduction medication review;
- Ensure timely payment of claims;
- Assure compliance with CMS statutory and regulatory requirements;
- Triage member's care needs;
- Review and analyze utilization data.

SNP Care Plans will be reviewed at least annually by the Interdisciplinary Care Team or as often as the member's health and social status requires ensuring ongoing improvement. Copies of the Care Plans are maintained in the member's records and copies distributed to the member and/or designated representative and all participants of the ICT. Members/caregivers have access to any and all documentation and may request that the Care Plans be shared with providers in other care settings.

ICPs will include an assessment of the following:

- Health status, including condition specific issues
- Clinical history, including medication history

- Activities of daily living
- Cognitive functioning
- Life Planning activities
- Cultural & Linguistics needs, preference and barriers
- Caregiver resources
- Discussion of plan benefits and member's health care preferences
- Add on services, ie. dental, vision/refraction services, respite and/or community service needs, etc., will be analyzed
- Setting realistic short term and long term goals and discussion regarding barriers to goals, with ultimate goal of self-management
- Schedule of communication with member and/or caregiver

ICT meetings may occur through a regularly scheduled Care Coordination Meeting, UM Committee Meeting, Conference Call, Written Correspondence, Confidential secure e-mailings and/or faxes, person to person direct interface or web-based team networking or through review of on-line shared electronic information for team meetings without a set schedule. These meeting will be documented in the form of minutes which will list attendees including team members, members and caregivers that may be present. Attendance will be taken and a minimum of 3 care team representatives will be present. The ICT meeting minutes will be attached to member's record.

ROLES AND RESPONSIBILITIES OF CORE INTERDISCIPLINARY CARE TEAM

Primary Care Physician [PCP]
In the role of Primary Care Physician, the PCP will be the designated team lead for the members ICT. PCPs will act as a gatekeeper and ensure timely and appropriate referrals within the contracted provider network. If services are required outside the provider network, the Interdisciplinary Care Team will be notified.

Medical Director
In the absence of the PCP, the Medical Director assumes the role of the designated team lead. The Medical Director acts as the liaison on clinical quality issues and is a resource for the Case Management Team in coordinating and addressing transitions of care and recommendations.

MSO Director of Case Management
The Director of Case Management has responsibility for administrative and clinical oversight of the Case Management staff including Nurse, Case Managers, and Personal Care Coordinators [PCC] and coordinates with the Medical Director to ensure delivery of Basic, Service, Care Coordination and Complex Case Management. The Director is the primary resource for all interdisciplinary care team meetings and acts as the group's designated resources for coordination of Behavioral Health services, Long Term Support Services, In Home Support Services, Community Based Adult Services, California Children's Services [CCS], Regional Center and other community based resources in the continuum of care. The Director of Case Management is responsible to update the Utilization Management and Quality Management Committee with the tracking and trending of all case management services.

MSO Case Manager, RN
The Case Manager is responsible for assessing members who may benefit from the case services. The Case Manager will identify members with conditions that would benefit from Complex Case Management and/or Disease Management. Where delegated the Case Manager performs assessments of the member's physical,

psychosocial and environmental conditions and reassessments with changed in health status or transitions of care. The Case Manager will be the key point of contact for the Personal Care Coordinators and for coordination with Community based services and health plan Disease Management programs. The Case Managers report to the Director of Case Management.

MSO Personal Care Coordinator
The PCC will serve as the primary point of contact for the Medicare and SPD members and will be an integral part of the member's interdisciplinary care team. The PCC assist members with obtaining appointments, any transportation needs and provides support to the member as they self-navigate the health care system. The PCC works closely with member's case management team to resolve access, medical and psychosocial related issues. The PCC must be able to efficiently manage and prioritize a caseload of 400 members. The Personal Care Coordinators report to the Director of Case Management.

Specialty Providers
The Specialists responsibility will include but is not limited to assessing, diagnosing, treating and conferencing with the Interdisciplinary Care Team, and contributing to the Individualized Care Plan [ICPs].

CARE TRANSITIONS

The Case Manager and PCP will work collaboratively to avoid unplanned transitions of care by coordinating services for members at high risk for hospitalization and educating members on self-management of their disease and regarding use of Emergency Room and/or Urgent Care services.

The Case Managers will collaborate with the Concurrent Review Team, Discharge Planners and Primary Care Physicians to ensure necessary care, services, and supports are in place in the community for members once they are discharged from hospital or institution including scheduling an outpatient appointment and/or conducting follow up with member and/or caregiver. Changes in a member's health status resulting from transitions of care trigger an automatic review of the member Care Plan. A system alert is placed in the member's record to inform all care team participants when a transition has occurred. The Case Manager is responsible to ensure that the PCP and specialist are notified of the transition. Records and information exchange is facilitated to prevent gaps or fragmentation of care. A Transition of Care call is placed to the member/caregiver within 24 hours of the transition. The member is engaged and encouraged to participate in the sharing of any changes in their condition with all members of the care team.

PCP's are notified of member's admissions through the Concurrent Review Process. The Concurrent Review Nurse and Case Manager will consider pre-admission status prior to the member's discharge and ensure member, caregiver/family member's understanding of the current conditions. This includes but may not be limited to, a review of the following:

1. Medical and functional condition
2. Medications, Infusion
3. Supplies, DME
4. Member, caregiver/family members placement preference
5. Pre-discharge counseling
6. SNF, Hospice and/or applicable Community Resources and programs
7. Special assistance, Home Health Nurse/Aide
8. Living arrangements,
9. Physical and mental function
10. Social Support

11. Financial support
12. Further institutional care
13. Transportation needs
14. Hospice
15. Other special needs

When members transition from a hospital setting to home or from a hospital setting to a skilled nursing facility, members are given a copy of their discharge plan with instructions to schedule a follow up visit with their Primary Care Physician. Providing members' access to their Personal Health Information [PHI] facilitates communication between providers across different heath care settings and fosters self-management skills. The designated Case Manager or PCC will place a follow up call within 24 hours of discharge to the member or the member's designated representative to ensure that all discharge plans were understood, being followed and to confirm that a follow appointment was set.

All Discharge plans are evaluated to assess any additional modification of existing care plan goals.

CONTINGENCY PLAN FOR CASE MANAGEMENT FUNCTIONS:

Designated Case Managers and PCCs are assigned to the SNP Care Management Program. Additional staff are cross-trained to ensure coverage in the event of absenteeism.

For any interruption in accessing member electronic records, the PCP and or the Health Plan will be contacted by the Case Management team to obtain a member's contact information and initiate a temporary manual documentation process. Once the system is available, the member's record is updated.

In the event that a member's phone access is interrupted, the Case Manager may send a letter to the member requested to contact their Case Manager or PCC to update contact information or to follow up on case management needs.

ANNUAL PROGRAM EVALUATION:

The Quality Improvement Committee [QIC] is responsible to assess policy changes, ensure adequate staffing, review the annual population assessment and make recommendations based on the findings, approve and ensure the use of appropriate clinical practice guidelines, ensure an adequate provider network and report the results internally and externally.

Through the annual review of member Care Plans, any gaps, barriers and/or challenges identified, trending in activity and the appropriate use of clinical practice guidelines and nationally recognized protocols are assessed and reported to the QIC. The QIC will make recommendations for remediation and improvement.

At case closure or upon annual re-assessment of open cases, members are surveyed regarding their satisfaction with the Care Management process. Members who participate in the Interdisciplinary Care Team meetings may be surveyed upon departure from the meeting.

The Medical Group will submit required data to the Health Plan and/or CMS as requested.

SUBJECT: Access to Care Standards **Policy #:** QM 10
DEPARTMENT: Quality Improvement

Effective Date: January 1998
Last Revision Date: September 29, 2021
Last Review: January 2023

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure that all members have adequate access to health care and receive services in a timely non-discriminatory manner.

POLICY:

All members shall have equal access to health care in timely manner.

All providers should have a scheduling system in place meeting all access standards. Missed appointments shall be documented in the members file. Providers will make 3 attempts to outreach to members who failed an appointment to reschedule appointments.

All providers are contractually required to notify the IPA of any changes in availability, telephone and facsimile number, or location of office within 30 days prior to effective date of change.

Members are encouraged to appropriately use the "911" emergency response system when they have an emergency medical condition which requires an emergency response.

Primary Care Providers will not discriminate against members relative to their health plan coverage in comparison to others.

An RN, Physician Assistant or Nurse Practitioner or the physician/provider may only perform telephone triage directly.

Quality Improvement will monitor access standards including accessibility, scheduling, wait times and member complaints, ongoing and formally on a yearly basis through the Access Study process. All Primary Care Providers and High-Volume Specialists will participate on the study with goal being that all providers meet 100% of the access standards. For those providers not meeting the access standards, a corrective action plan will be put in place and monitored by Quality Improvement. A random re-audit will be performed to ensure correction.

Results from the study will be entered into the provider profile for re-credentialing purposes.

DEFINITIONS[i]:

Advanced Access means the provision, by an individual provider, or by the medical group or independent practice association to which a member is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day.

Ancillary service includes, but is not limited to, providers of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers" [as defined by H&S Code Section 1323(e)(1)].

Appointment waiting time means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.

Discrimination: Treating a member differently from any other privately or publicly covered patient in the provision of a covered service or accessibility on the basis that the member is eligible, or on the basis of race, color, creed, religion, ancestry, martial status, sexual orientation, national origin, age, sex, language, or mental or physical disability.

Emergency Medical Condition: A medical condition, which 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:

1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or
2. Serious impairment to bodily function; or
3. Serious dysfunction of any body part or organ.

Emergency Services: Inpatient or Outpatient covered services furnished by a qualified provider, which are needed to evaluate or stabilize an Emergency Medical Condition, including at a minimum, a Medical Screening Examination to determine the presence or absence of an Emergency Medical Condition.

Provider means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services [as defined by H&S Code Section 1345(i)].

Preventive care means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full-service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.

Routine Primary Care: The evaluation and treatment of non-acute problems for new and established patients.

Specialist is defined as a residency-trained, board-certified or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA).

Cont. DEFINITIONS:

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (real-time or near real-time two-way transfer of medical data and information). Neither a telephone conversation nor an electronic mail message between a health care practitioner and member constitutes telemedicine for the purposes of this policy and procedure.

Triage or Screening means the assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care. There will be no cost share towards member

Triage or screening waiting time means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

Urgent Care Services: means health care for a condition which requires prompt attention when the enrollee's condition is such that the member faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function (consistent with subsection (h)(2) of Section 1367.01 of the Act).

PROCEDURE:

A. ACCESS STANDARDS:

Commercial Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent Care appointments for Primary Care (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)[1]	Not to exceed 15 minutes

[1] As per DMHC Access & Availability Technical Assistance Guide Section AA-05, 1.5, and T28 CCR §1300.67.2 (f) & 1300.67.2.1(c)(13) & ICE Provider Appointment Access Policy & Procedure Template

Behavioral Health Emergent & Non-Emergent Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider [i.e. Psychologist, Licensed Clinical Social Worker, and Marriage and Family Therapist]	Must offer the appointment within 10 business days of request. Appointment for follow-up routine care with a non-physician behavioral health care provider within twenty (20) calendar days of initial visit for a specific condition.
Urgent Care appointments	Must offer the appointment within 48 hours of request
Access to Care for Non-Life Threatening Emergency	Within 6 hours
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for mental illness	Must Provide Both: One follow-up encounter with a mental health provider within 7 calendar days after discharge, plus One follow-up encounter with a mental health provider within 30 calendar days after discharge

(These standards do not apply where members have direct access to Behavioral Health Services or sites.)

Medi-Cal Non-Emergent Medical Appointment Access Standards

Access Measure	Time-Elapsed Standard
Access to PCP or designee	24 hours a day, 7 days a week
Non-urgent Care appointments for Primary Care (PCP Regular and Routine, excludes physicals and wellness checks)	Must offer the appointment within 7 business days of request
Adult physical exams and wellness checks	Must offer the appointment within 30 calendar days of request
Non-urgent appointments with Specialist physicians (SCP Regular and Routine)	Must offer the appointment within 15 business days of request
Urgent Care appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office)	Must offer the appointment within 24 hours of request
Urgent Care appointments that require prior authorization (SCP)	Must offer appointment within 96 hours of request
First Prenatal Visit	Must offer the appointment within 5 business days of request; Non-urgent 3rd trimester and high risk – within 3 calendar days
Child physical exam and wellness checks with PCP	Must offer the appointment within 10 business days of request
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Initial Health Assessment (members age 18 months and older)	Must be completed within 120 calendar days of enrollment
Initial Health Assessment (members age 18 months and younger)	Must be completed within 60 calendar days of enrollment
Sensitive Services Appointment	Preferably within 24 hours but no later than 48 hours

Medicare/Medicare Advantage Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Access to PCP or designee	24 hours a day, 7 days a week
Adult physical exams and wellness checks	Must offer the appointment within 30 calendar days of request
Non-urgent Care appointments for Primary Care (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)[2]	Not to exceed 15 minutes
Non-Physicians Mental Health Provider	Must offer the appointment within 10 Business Days of the request
After Hours and Emergent Care	24 hours a day, 7 days a week
Member Services, by telephone	During normal business hours

EXCEPTIONS:

Preventive Care Services and Periodic Follow Up Care:
Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists or chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Advance Direct Access:
A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance direct access to primary care appointments as defined herein.

Appointment Rescheduling:
When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

[2] As per DMHC Access & Availability Technical Assistance Guide Section AA-05, 1.5, and T28 CCR §1300.67.2 (f) & 1300.67.2.1(c)(13) & ICE Provider Appointment Access Policy & Procedure Template

Extending Appointment Waiting Time:
The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

Interpreter Services
Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. *See Interpreting Services P&P QM15.*

Prior Authorization Processes
Prior authorization processes are to be completed in a manner that assures the provision of covered health care services to members in a timely manner appropriate for the member's condition and in compliance with the requirements of the time-elapsed access standards. *See ICE Timeliness Standards for Referral timeliness Requirement. For LA Care Health Plan – See LA Care's Timeliness Requirements.*

Shortage of Providers
To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer members to available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health needs. Furthermore, providers shall arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the member's condition.

Member costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating a member's preference to wait for a later appointment from a specific contracted provider

Triage &/or Screening
All Providers shall provide or arrange for the provision of 24/7 triage or screening services by telephone and ensure that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

The Provider must at a minimum maintain a procedure for triaging or screening member telephone calls, which shall include the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:

a. Regarding the length of wait for a return call from the provider (not to exceed 30 minutes); and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

If a member calls after hours or on a weekend for a possible medical emergency, the Provider is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

- Answering service/office staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

- The answering service should document all calls.

Telemedicine

To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established.

Prior to the delivery of health care via telemedicine, the provider must obtain verbal and written informed consent from the member or the member's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the member or the member's legal representative verbally and in writing:

1. The member or the member's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the member or the member's legal representative would otherwise be entitled.
2. A description of the potential risks, consequences, and benefits of telemedicine.
3. All existing confidentiality protections apply.
4. All existing laws regarding member access to medical information and copies of medical records apply.
5. Dissemination of any member identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the member.

A member or the member's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the member or the member's legal representative understands the written information provided and that this information has been discussed with the health care practitioner, or his or her designee. The written consent statement signed by the member or the member's legal representative shall become part of the member's medical record.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

For Medi-Cal Managed Care, all telehealth providers must comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.

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 via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers.

B. TELEPHONE ACCESS STANDARDS:

1. Non-Emergent member telephone messages to be returned within 24 hours.

2. Urgent telephone calls must be returned by the physician or his "on-call" coverage immediately.

3. Members are encouraged to appropriately use the "911" emergency response system when they have an emergency medical condition which requires an emergency response.

4. Clinical advice can only be provided by appropriately qualified staff (i.e., physician, physician assistant, nurse practitioner or registered nurse.)

C. ACCESS MONITORING PROCEDURE:

1. The Member Services Department, on an ongoing basis, will monitor telephone access and member complaints regarding access to providers.

2. On an annual basis, the Member Services Department will monitor telephone access by contacting provider offices during office hours and after hours via telephone with a list of scenarios for each criterion. Findings are recorded on the NCQA "Primary Care Provider/Specialist Tally Sheet".

3. All findings are forwarded to Quality Improvement Committee for review, with a summary comparison of previous year findings, to monitor improvement or need for improvement. In some cases, the health

plan may perform these studies and the group will review the plans findings and address corrective action where identified.

4. Based on the results of the study, the Quality Improvement Committee may request corrective action to be implemented. Corrective Action may include, but is not limited to, In-service of Provider and office staff, increase medical staff/FTE's, developing of policy and procedure to meet Access Standards, Extend office hours, etc.

5. Wait Times are monitored through the Member Satisfaction Study.

6. Member Satisfaction Study results are reported to the Quality Improvement Committee.

D. IPA/MSO ACCESS STANDARDS:

1. Members and Providers can utilize a statewide toll-free number, 24 hours a day/ 7 days a week for telephonic assistance.

2. The MSO staff will be available at least 8 hours a day, during normal business hours for incoming and outgoing calls. All employees will identify themselves for each incoming and outgoing call.

3. For After hours coverage, the IPA and MSO will have an Answering Service or process to contact designated employees for urgent calls via pager/cell phone. Any Utilization Outpatient or Inpatient authorization activity will be directed to the IPA's Medical Director for approval and/or direction. Only a physician will give medical advice. All After-Hours calls will be logged and followed up on the next business day.

4. If a member contacts the MSO through a collect call process, the Staff member will accept the call to address the member's needs.

5. All reasonable efforts will be made to provide an interpreter in time to adequately assist with all questions and concerns.

FORMS:
Primary Care Provider/Specialist Tally Sheet.

REFERENCES:
NCQA QI5

[i] Cal Optima – Access to Health Care Policy# GG.1600

Individual Housing Transition Services: Services that support members in being successful tenants in their housing arrangement, thus able to sustain tenancy.

Long Term Support Services: A wide variety of services and supports that help members meet their daily needs for assistance and improvement of the quality of their lives. LTSS are provided over an extended period, predominately in homes and communities, but also facility-based setting such as nursing facilities. Covered LTSS includes Community Based Adult Services (CBAS, In-Home Supportive Services (IHSS), Multipurpose Senior Service Program (MSSP) services and Skilled Nursing Facility services and Subacute care services.

Notice of Action: Written notice informing a member of an adverse benefit determination.

Palliative Care: Patient and family centered care that optimizes quality of life by anticipating, preventing and treating suffering.

Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT): A survey administered to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons.

Well-Managed: Members with HHP Chronic conditions that (a) do not have a pattern of utilization of negative outcomes that are an indication of poor chronic disease management or patient activation or (b) are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, that determines the member's eligible chronic condition are already well managed to the extent that the HHP services are not medically necessary and will not significantly change the member's health status.

PROCEDURE:

1) When delegated for HHP, the group will collaborate with the plan on targeted, progressive engagement for member's identified on the Finalized Engagement List [FEL].

2) The Nurse will open a case in the system for all members identified in the FEL.

3) A minimum of three (3) progressive attempts to engage the member within the 1st 90 days of the program onset. Progressive engagement may include but is not limited to, mailed and other written communication, live calls and in person engagement.

4) Outreach attempts and member decisions will be documented and maintained in the system for reporting purposes.

5) Where necessary, outreach activity may include processes to validate and update contact information which may require collaboration with community partners or providers for which there is documentation of prior services.

6) When all efforts have been exhausted and outreach is unsuccessful, an unable to contact notice will be mailed and the case will be closed in the system.

7) When a member is reached, the benefits of the HHP program will be explained to the member.
   a) If the member refuses participation, it will be documented in the system and the case will be closed.
   b) If the member elects to participate in the HHP:

1. The system will have an alert set for identification of HHP eligible members that opted in.
2. Discussion will take place regarding best time and options for contact.
3. The member will be educated on the roles and responsibility of the multi-disciplinary HHP Care Team and other providers, member or their designated representative upon engagement into HHP.

4. An initial Heath Needs Assessment will be performed.

    i. The HNA will assess current health status, resource needs, referral needs, determine the members level of engagement and readiness for participation, identify the member's perceived gaps in care, coaching needs for self-management skills and self-directed care at agreed level or participation, set agreed goals and time for follow up call.

    ii. As part of the HNA, referral and coordination may begin with a Housing Navigator or Community Health Worker for face to face or appointment accompaniment.

    iii. The HNA will be maintained in the system.

    iv. A Welcome packet will be sent to the member.

5. A Health Assessment Plan (HAP) will be developed within 90 days of the member opting into HHP.
    i. A copy of the HAP will be sent to the PCP and HHP Care Team members.

6. Case Conferences will be scheduled an update to the HAP may be made based upon the recommendations in the case conference.

7. The HAP will be re-reviewed at any transition of care and/or change in health status. An assessment to determine if an update to the HAP is needed. Outreach to the member and/or face to face visit may be coordinated.

8. The HHP Care Team will be notified in change of status. The IPA will make a special effort to coordinate care when members move from one setting to another such as transitions from a member's usual setting of care to the hospital and when they are discharged from a hospital to next setting. This includes but is not limited to transitions from home to acute care, from acute care to nursing facility and/or sub-acute facility and to home, or residential/treatment facility or other treatment setting, or out of an incarceration facility, by providing evidence-based transitional care.

    i. Planned transitions are identified on the IPA concurrent review log. This log is reviewed daily by Case Manager.

    ii. For planned or unplanned transitions, sharing of the member's Care Plan is done within one business day by Hospitalist to Attending Physician or Case Manager to Case Manager or Discharge Planner.

    iii. For planned or unplanned transitions from any setting, communication with the member or responsible party about changes to the member's health status and plan of care will occur within 1 business day.

iv. The member's PCP will be notified of the member's planned and unplanned transition by faxing the member's facility face sheet to the PCP within 1 business day.

v. The CM or designee will contact the member to ensure scheduling of an outpatient appointment and/or conducting follow-up with the patient and or caregiver. Appointments with Primary Care Physician or Specialist should occur no later than 5 days post discharge or within timeframe defined by the discharging physician.

9. The Care Management process will be consistent with the groups Case Management program and will incorporate the Housing Navigators and Community Workers.

10. If a member is involuntarily disenrolled from the HHP due to no longer meeting the HHP eligibility requirement or an exclusion is identified, the member will receive a Notice of Action (NOA) Letter.

11. Continuous daily monitoring of staff assignments will occur to ensure adequate staffing coverage.

12. For CalOptima, the group will submit HHP Billing Data to the plan by the 15th of the month using the CalOptima proprietary format.

FORMS:



Health Homes Program (HHP)

PROVIDER TRAINING

Course Content

- Overview
- Who Can Join HHP?
- When Can Members Join HHP?
- How Can HHP Services Help Members?
- How a Member can sign up for HHP?
- Is there a Cost to Members?
- Resources

Health Homes (HHP) Overview

- HHP services are for members with certain chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long term services and supports (LTSS) for members with chronic conditions.

Who can join HHP?

- Members may be contacted if they qualify for the program. Members can also call Noble Mid-Orange County, CalOptima, or talk to their doctor to find out if members qualify to receive HHP Services.
- Members may qualify for HHP if:
  1. The have Medi-Cal coverage and be enrolled in CalOptima
  2. Have certain chronic health conditions:
     - Chronic physical condition or combination of these conditions (i.e. asthma, kidney or liver disease, hypertension, heart failure, Substance Use Disorder (SUD), etc.) or
     - Serious Mental Illness (SMI)

Members may qualify for HHP if (cont.):

3. Have three (3) or more of the HHP eligible conditions
4. Have stayed in the hospital in the last year
5. Have visited the emergency department three (3) or more times in the last year; or
6. Experiencing chronic homelessness

Member do not qualify to receive HHP services if:

1. Members receive hospice services; or
2. Member have been residing in a skilled nursing facility for longer than the month of admission and the following month.

When Can Members Join?

- **January 1, 2020** for members with chronic conditions only and
- **July 1, 2020** for those with Serious Mental Illness (SMI), with or without chronic conditions

How Can HHP Services Help Members?

HHP services includes:

1. **Personal Care Coordinators (PCCs)**
   - A Personal Care Coordinator to answer and arrange services for the members
2. **Comprehensive Care Management & Transitional Care**
   - To keep the member and their providers up-to-date about the members health care needs, meet health goals and help stay healthy, help move safely and easily between care setting
3. **Health Education/Promotion**
   - To assist the member in learning the best ways to manage their health
2. **Individual & Family Support Services**
   - To help strengthen the member and their support system with their health care goals
2. **Connection to Community Services**
   - To help find and apply for services, such as food, disability and housing related services.

How can a Member sign-up for HHP?

- Member can contact their provider. If the member qualifies, the provider can refer the member to contact Noble Mid-Orange County at **1-888-880-8811.**

THE PROGRAM IS VOLUNTARY
AND THE MEMBER CAN STOP THE HHP SERVICES AT ANYTIME.

Is there a cost to Members?

- There is no cost to the member for HHP services.

Resources

Attached and Link to the Orange County Referral Sources for Health Homes Program: A Guide to Local Directories & Specialized Organizations

https://www.caloptima.org/en/ForProviders/Resources/ManualsPoliciesandGuides.aspx


Protecting Your Family's Health
Noble-Mid Orange County
888.880.8811
www.noblemidoc.com

CalOptima
A Public Agency
Better. Together.

ORANGE COUNTY REFERRAL SOURCES FOR HEALTH HOMES PROGRAM

January 2021

A Guide to Local Directories & Specialized Organizations

Contents

Introduction and General Instructions for Use 2
Organization 2
Selection 2
Disclaimer 2
More Information 2
Section 1: **Broad Resource Directories** 3
Section 2: **Chronic Conditions** 4
Asthma 4
Bipolar Disorder 4
Chronic Liver Disease 5
Chronic Obstructive Pulmonary Disease (COPD) 6
Congestive Heart Failure (CHF) 6
Coronary Artery Disease (CAD) 6
Dementia 7
Diabetes (or Risk of Diabetes) 7
Hypertension 8
Major Depression (or Risk of Depression) 8
Obesity (or Risk of Obesity) 9
Psychotic Disorder 10
Serious Mental Illness 11
Substance Use Disorder (or Risk of SUD) 11
Traumatic Brain Injury (TBI) 12
Section 3: **Target Populations** 14
Chronic Homelessness 14
Other Acuity/Complexity Criteria 14

Introduction and General Instructions for Use

Organization

This informational guide has been organized to assist Health Homes Program (HHP) providers in quickly identifying relevant resource directories and specialized organizations that may be contacted as the “go-to” sources for information on local services targeting specific HHP-related conditions or populations.

This guide is organized by HHP-related conditions and populations.

- Section 1: Providers of broad resource directories that may be relevant to all HHP participants and their families/personal supports.
- Section 2: Providers of resource directories containing services relevant to the chronic conditions set forth in the Department of Health Care Services (DHCS) eligibility criteria for HHP. Also, specialized organizations focusing on one or more of those chronic conditions.
- Section 3: Providers of resource directories containing services relevant to the HHP target populations, as established by the DHCS’ acuity/complexity criteria.

Selection

The resource directories and specialized organizations in this directory were selected because they offer comprehensive or targeted service referrals for HHP-related conditions and populations. This guide is not intended to serve as a complete list of all resource directories or all services available for HHP-related populations. Rather, this guide may be used as a starting point for identifying appropriate resources for each participant.

Disclaimer

Inclusion in the guide does not imply endorsement, and omission does not indicate disapproval. CalOptima neither guarantees nor makes any representation as to the accuracy or completeness of the information contained in this guide. CalOptima disclaims any and all responsibility and liability that may be asserted or claimed resulting from or arising out of reliance upon the information and procedures presented in the directory. CalOptima reserves the right to edit information to meet DHCS and other guidelines, and for format, and space requirements.

More Information

For more information about this guide and/or updates to its contents, please contact CalOptima’s Provider Relations Department at (714) 246-8600.

CalOptima thanks Upswing Group for their support in developing this directory.

Section 1: **Broad Resource Directories**

The resource directories on this page may be useful to a variety of participants and their families/personal supports.

2-1-1 Orange County (211OC)

Maintains various resources for patients and their caregivers.
Tips: Keyword search or ask specialist for resources based on participants' conditions or specific needs (see Chronic Conditions section below for more information), or search for "caregiver" resources, or the specific service for which you would like to search (such as "caregiver consultation and support", "caregiver counseling", etc.)
Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.
Resource Directories URL: https://www.211oc.org/get-help.html
24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)
Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Aging and Disability Resource Connection of Orange County (ADRCOC)

Types of Listings: Information and resources for older adults, people with disabilities, family members, caregivers, and those seeking options counseling for long-term care/support.
Toll Free: (800) 510-2020 *(phone assistance from ADRC specialists recommended)*
Resource Directories URL: http://www.navigateresources.net/adrcoc
General URL: http://adrcoc.org

Family Caregiver Resource Center Orange County

Types of Listings: Support groups, self-care resources, respite assistance, family consultations, counseling, elder law, fact sheets, education, general information related to caregiving, etc.
Toll Free: (800) 543-8312 or **Local:** (714) 446-5030
General URL: http://www.caregiveroc.org

This guide continues with Section 2 on the next page.

Section 2: **Chronic Conditions**

The next several pages contain resource directories and specialized organizations, organized alphabetically by the chronic conditions listed in the Department of Health Care Services eligibility criteria for the Health Homes Program.

Asthma

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “asthma” resources or the specific service for which you would like to search (such as “chronic disease self-management programs”, “health/disability related support groups”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Bipolar Disorder

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “bipolar” resources or the specific service for which you would like to search (such as “mental health related support groups”, “individual counseling”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Depression and Bipolar Support Alliance – Orange County Chapter (DBSA-OC)

Types of Listings: Support group meetings

Local: (714) 744-8718

General URL: http://dbsaoc.org (Click “Meeting List” for support group meetings)

Section 2 continues with additional resource directories for bipolar disorder on the next page.

National Alliance on Mental Illness, Orange County (NAMI OC)

Types of Listings: Resources for people with mental illness and their families/personal supports including support groups, legal resources, education programs, treatment resources, and other resources.
OC WarmLine: (714) 991-6412
Live Chat: https://m2.icarol.com/ConsumerRegistration.aspx?org=2178&pid=80&cc=en-US
General URL: www.namioc.org

Mental Health Association of Orange County (MHA OC)

Types of Listings: Focuses on adults with severe and persistent psychiatric disorders. Support groups, emergency/crisis, evaluation & treatment, mental health phone assistance, local nonprofit and government services, housing and homelessness services, substance abuse services, and hoarding.
Local: (714) 547-7559
Resource Directories URL: https://mentalhealthca.wordpress.com/
General URL: www.mhaoc.org

Orange County Behavioral Health Information & Referrals (OC Links)

Types of Listings: Information and linkage to Orange County Health Care Agency's Behavioral Health Services including children and adult mental health, alcohol and drug inpatient and outpatient, crisis programs, and prevention and early intervention services.
Toll Free: (855) OC-LINKS (625-4657)
Resource Directory and Online Help Request (request for a specialist to contact you with resources): http://www.ochealthinfo.com/oclinks

Chronic Liver Disease

2-1-1 Orange County (211OC)

Maintains various resources for this condition.
Tips: Keyword search ("search all fields") or ask specialist for: "liver" resources or the specific service for which you would like to search (such as "chronic disease self-management programs", "Health/Disability Related Support Groups", etc.)
Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.
Resource Directories URL: https://www.211oc.org/get-help.html
24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)
Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Section 2 continues on the next page.

Chronic Obstructive Pulmonary Disease (COPD)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search ("search all fields") or ask specialist for: "lung" resources or the specific service for which you would like to search (such as "chronic disease self-management programs", "health/disability related support groups", etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Congestive Heart Failure (CHF)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: "heart disease" resources or the specific service for which you would like to search (such as "friendly telephoning", "chronic disease self-management programs", "health/disability related support groups", etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: Community Service Directory-- Attestation 13.G.msg

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Coronary Artery Disease (CAD)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: "heart disease" resources or the specific service for which you would like to search (such as "friendly telephoning", "chronic disease self-management programs", "health/disability related support groups", etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Section 2 continues on the next page.

Dementia

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “dementia” resources or the specific service for which you would like to search (such as “friendly visiting”, “case/care management”, “dementia management”, “caregiver/care receiver support groups”, “health/disability related support groups”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Alzheimer’s Orange County

Types of Listings: Housing options (assisted living, skilled nursing, etc.), elder law resources, hospice, transportation, home health care, adult daycare medical services, elder transportation resources, community services, education, support, social engagement, etc.

24/7 Helpline: (800) 272-3900

Resource Directories URL: https://www.alz.org/we_can_help_we_can_help.asp

General URL: www.alzoc.org

Diabetes (or Risk of Diabetes)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “diabetes” resources or the specific service for which you would like to search (such as “chronic disease self-management programs”, “diabetes management clinics” “health/disability related support groups”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Section 2 continues on the next page.

Hypertension

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “hypertension” or the specific service for which you would like to search (such as “chronic disease self-management programs”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Major Depression (or Risk of Depression)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “depression” resources or the specific service for which you would like to search (such as “mental health related support groups”, “individual counseling”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Depression and Bipolar Support Alliance – Orange County Chapter (DBSA-OC)

Types of Listings: Support group meetings

Local: (714) 744-8718

General URL: http://dbsaoc.org (Click “Meeting List” for support group meetings)

National Alliance on Mental Illness, Orange County (NAMI OC)

Types of Listings: Support groups, legal resources, education programs, treatment resources, and other resources for people with mental illness and their families/personal supports.

OC WarmLine: (714) 991-6412

Live Chat: https://m2.icarol.com/ConsumerRegistration.aspx?org=2178&pid=80&cc=en-US

General URL: www.namioc.org

Section 2 continues with additional resource directories for depression on the next page.

Mental Health Association of Orange County (MHA OC)

Types of Listings: Focuses on adults with severe and persistent psychiatric disorders. Support groups, emergency, crisis, evaluation & treatment, mental health phone assistance, local nonprofit and government services, housing and homelessness services, substance abuse services, and hoarding.
Local: (714) 547-7559
Resource Directories URL: https://mentalhealthca.wordpress.com/
General URL: www.mhaoc.org

Orange County Behavioral Health Information & Referrals (OC Links)

Types of Listings: Information and linkage to Orange County Health Care Agency's Behavioral Health Services including children and adult mental health, alcohol and drug inpatient and outpatient, crisis programs, and prevention and early intervention services.
Toll Free: (855) OC-LINKS (625-4657)
Resource Directory and Online Help Request (request for a specialist to contact you with resources): http://www.ochealthinfo.com/oclinks

Obesity (or Risk of Obesity)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.
Tips: Keyword search or ask specialist for: "obesity", "weight", "weight loss", "weight related support groups", "overeating/food addiction" resources
Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.
Resource Directories URL: https://www.211oc.org/get-help.html
24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)
Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Section 2 continues on the next page.

Psychotic Disorder

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search (set to "Search All Fields") or ask specialist for: "psychosis" resources or the specific service for which you would like to search (such as "mental health related support groups", "individual counseling", etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

National Alliance on Mental Illness, Orange County (NAMI OC)

Types of Listings: Support groups, legal resources, education programs, treatment resources, and other resources for people with mental illness and their families/personal supports.

OC WarmLine: (714) 991-6412

Live Chat: https://m2.icarol.com/ConsumerRegistration.aspx?org=2178&pid=80&cc=en-US

General URL: www.namioc.org

Mental Health Association of Orange County (MHA OC)

Types of Listings: Focuses on adults with severe and persistent psychiatric disorders. Support groups, emergency, crisis, evaluation and treatment, mental health phone assistance, local nonprofit and government services, housing and homelessness services, substance abuse services, and hoarding.

Local: (714) 547-7559

Resource Directories URL: https://mentalhealthca.wordpress.com/

General URL: www.mhaoc.org

Orange County Behavioral Health Information & Referrals (OC Links)

Types of Listings: Information and linkage to Orange County Health Care Agency's Behavioral Health Services including children and adult mental health, alcohol and drug inpatient and outpatient, crisis programs, and prevention and early intervention services.

Toll Free: (855) OC-LINKS (625-4657)

Resource Directory and Online Help Request (request for a specialist to contact you with resources): http://www.ochealthinfo.com/oclinks

Section 2 continues on the next page.

Serious Mental Illness

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “mental illness” resources or the specific service for which you would like to search (such as “mental health related support groups”, “individual counseling”, etc.)
Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.
Resource Directories URL: https://www.211oc.org/get-help.html
24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)
Online Help Request: http://www.211oc.org/get-help/online-help-request.html

National Alliance on Mental Illness, Orange County (NAMI OC)

Types of Listings: Support groups, legal resources, education programs, treatment resources, and other resources for people with mental illness and their families/personal supports.
OC WarmLine: (714) 991-6412
Live Chat: https://m2.icarol.com/ConsumerRegistration.aspx?org=2178&pid=80&cc=en-US
General URL: www.namioc.org

Mental Health Association of Orange County (MHA OC)

Types of Listings: Focuses on adults with severe and persistent psychiatric disorders. Support groups, emergency, crisis, evaluation and treatment, mental health phone assistance, local nonprofit and government services, housing and homelessness services, substance abuse services, and hoarding.
Local: (714) 547-7559
Resource Directories URL: https://mentalhealthca.wordpress.com/
General URL: www.mhaoc.org

Orange County Behavioral Health Information & Referrals (OC Links)

Types of Listings: Information and linkage to Orange County Health Care Agency’s Behavioral Health Services including children and adult mental health, alcohol and drug inpatient and outpatient, crisis programs, and prevention and early intervention services.
Toll Free: (855) OC-LINKS (625-4657)
Resource Directory and Online Help Request (request for a specialist to contact you with resources): http://www.ochealthinfo.com/oclinks

Section 2 continues on the next page.

Substance Use Disorder (or Risk of SUD)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “substance use disorder” resources or the specific service for which you would like to search (such as “detox”, “residential treatment”, “drug use disorder support groups”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Orange County Alcoholics Anonymous (AA)

Types of Listings: Peer support meetings and clubs/fellowship halls for people recovering from alcohol addiction

General URL: http://www.oc-aa.org/

24/7 Office Line: (714) 556-4555

Orange County Behavioral Health Information & Referrals (OC Links)

Types of Listings: Information and linkage to Orange County Health Care Agency’s Behavioral Health Services including children and adult mental health, alcohol and drug inpatient and outpatient, crisis programs, and prevention and early intervention services.

Toll Free: (855) OC-LINKS (625-4657)

Resource Directory and Online Help Request (request for a specialist to contact you with resources): http://www.ochealthinfo.com/oclinks

Orange County Narcotics Anonymous (NA)

Types of Listings: Peer support meetings and activities for people recovering from drug addiction

General URL: https://www.orangecountyna.org

24/7 Helpline: (714) 590-2388

Traumatic Brain Injury (TBI)

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “brain injury” resources or the specific service for which you would like to search (such as “brain injury rehabilitation”, “health/disability related support groups”, “speech and language pathology”, “individual advocacy”, “case/care management”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

St. Jude Brain Injury Network

Types of Listings: Support groups, rehabilitation, colleges with brain injury programs, veteran resources, government resources, local community resources, other brain injury organizations.
Toll Free: (866) 785-8332 or Local: (714) 446-5626
Resource Directory URL: http://tbioc.org/resources/
Support Groups URL: tbioc.org/supportgroups/
General URL: www.tbioc.org

This guide continues with Section 3 on the next page.

Section 3: **Target Populations**

The directories on this page are organized by the criteria for establishing acuity/complexity listed in the Department of Health Care Services (DCHS) Eligibility Criteria for the Health Homes Program.

Chronic Homelessness

2-1-1 Orange County (211OC)

Maintains various resources for this condition.

Tips: Keyword search or ask specialist for: “homeless” resources or the specific service for which you would like to search (such as “transitional housing”, “housing search assistance”, “homeless permanent supportive housing”, “case/care management”, “homeless motel vouchers”, etc.)

Types of Listings: Comprehensive directory of nonprofit and government health and human services resources serving Orange County.

Resource Directories URL: https://www.211oc.org/get-help.html

24/7 Helpline: 2-1-1 or (888) 600-HELP (4357)

Online Help Request: http://www.211oc.org/get-help/online-help-request.html

Other Acuity/Complexity Criteria

Participants with three of the eligible conditions, or one inpatient stay in the last 12 months, or three Emergency Department visits in the last 12 months.

Aging and Disability Resource Connection of Orange County (ADRCOC)

Types of Listings: Information and resources for older adults, people with disabilities, family members, caregivers, and those seeking options counseling for long-term care/support.

Toll Free: (800) 510-2020 *(phone assistance from ADRC specialists recommended)*

Resource Directories URL: http://www.navigateresources.net/adrcoc

General URL: http://adrcoc.org

Orange County Behavioral Health Information & Referrals (OC Links)

Types of Listings: Information and linkage to Orange County Health Care Agency’s Behavioral Health Services including children and adult mental health, alcohol and drug inpatient and outpatient, crisis programs, and prevention and early intervention services.

Toll Free: (855) OC-LINKS (625-4657)

Resource Directory and Online Help Request (request for a specialist to contact you with resources): http://www.ochealthinfo.com/oclinks

Community Resource List – Orange County

2-1-1 Orange County
http://www.infolinkoc.org

Access California Services
http://www.accesscal.org

Age Well Senior Services, Inc.
http://www.myagewell.org

South County Adult Day Services
http://www.myagewell.org

Aging & Disability Resource Connection of Orange County (ADRC)
http://www.adrcoc.org

AIDS Services Foundation Orange County
http://www.ocasf.org

Alzheimer's Association Orange County Chapter
http://www.alz.org/oc/

Alzheimers Family Services Center
http://www.afscenter.org

American Cancer Society (ACS)
http://www.cancer.org

American Academy of Pediatrics (AAP)
http://www.aap.org/

American Association of Retired Persons (AARP)
http://www.aarp.org

American Red Cross Orange County
http://www.redcross.org/ca/orange-county

Beacon Health Strategies
http://www.beaconhealthstrategies.com

Braille Institute
http://www.brailleinstitute.org

California STD/HIV Prevention Training Center
http://www.stdhivtraining.org

Caregiver Resource Center
http://www.caregiveroc.org/

Casa de la Familia
http://www.casadelafamilia.org/

Children and Families Commission of Orange County
http://www.occhildrenandfamilies.com/

Children's Health Initiative of Orange County (CHIOC)
http://www.hfpoc.org/chioc/

CHOC Children's
http://www.choc.org

Coalition of Orange County Community Clinics
http://www.coccc.org/

Community SeniorServ
http://www.communityseniorserv.com

Council on Aging – Orange County
http://www.coaoc.org

Health Insurance Counseling and Advocacy Program (HICAP)
http://www.coaoc.org/programs-and-services/hicap...

Long-Term Care Ombudsman
http://www.coaoc.org/html/services_ombudsman_description.htm

Dayle McIntosh Center
http://www.daylemc.org/

Disability Rights Legal Center
http://www.disabilityrightslegalcenter.org

Epocrates®
http://www.epocrates.com

Families and Communities Together (FaCT) - Family Resource Centers
http://ochealthinfo.com/phs/about/family/occp/profiles/fact

Family Autism Network
http://www.faninfo.org

Family Support Network
http://www.familysupportnetworkca.com/

Goodwill Industries of Orange County / ATEC
http://www.ocgoodwill.org

Health Funders Partnership of Orange County
http://www.hfpoc.org

Help Me Grow Orange County
http://www.helpmegrowoc.org

Horizon Cross Cultural Center
http://www.anselmcenter.org/

Hurtt Family Clinic - Orange County Rescue Mission
http://www.rescuemission.org/MainTabs/Services/HurttFamilyHealthClinic.aspx

Hy-Lond Home/ResCare
http://www.rescare.com

ImmunizationEd
http://www.immunizationed.org

Integrated Healthcare Holdings, Inc.
http://www.ihhioc.com/

Information on Smallpox and Smallpox Vaccination Programs
http://www.bt.cdc.gov/agent/smallpox/vaccination/

Improving Preventive Care Services for Children
http://www.chcs.org/publications3960/publications_show.htm?doc_id=212873

Irvine Health Foundation
http://www.ihf.org/

Korean Community Services
http://www.koreancommunity.org/

Legal Aid Society of Orange County
http://www.legal-aid.com/

LIBERTY Dental Plan
http://www.libertydentalplan.com

Mercy House
http://www.mercyhouse.net

National Children's Study
http://www.nationalchildrensstudy.gov...

Nhan Hoa Clinic
http://www.nhanhoa.org

National Transitions of Care Coalition (NTOCC)
http://www.ntocc.org

Orange County Adult Day Services Coalition
http://www.ocadultdayservices.org/

OCTA ACCESS Service
http://www.octa.net/bus-access-service.aspx

Orange County Affiliate of Susan G. Komen for the Cure
http://www.komenoc.org

Orange County Asian and Pacific Islander Community Alliance (OCAPICA)
http://www.ocapica.org/

Orange County Head Start, Inc.
http://www.ochsinc.org/

Orange County Health Needs Assessment
http://www.ochna.org

Pacific Islander Health Partnership (PIHP)
http://pacificislanderhealthpartnership.net

Planned Parenthood of Orange and San Bernardino Counties
http://www.plannedparenthood.org/orange-san-bernardino

Public Law Center - Orange County
http://www.publiclawcenter.org

Regional Center of Orange County (RCOC)
http://www.rcocdd.com

St. Joseph Hospital
http://www.sjo.org/

Share Our Selves (SOS)
http://www.shareourselves.org/

The Leukemia & Lymphoma Society Orange County and Inland Empire
http://www.lls.org

UCI Center of Excellence on Elder Abuse and Neglect
http://www.centeronelderabuse.org

UCI - Institute for Clinical and Translational Science
http://www.icts.uci.edu

Vietnamese Community of Orange County (VNCOC)
http://www.thevncoc.org

Vision Service Plan (VSP)
https://www.vsp.com/

VITAS Innovative Hospice Care
https://www.vitas.com

COMMUNITY RESOURCES, SOCIAL AND SUPPORTIVE SERVICES

NOBLE ORANGE COUNTY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY

Woman, Infant and Children (WIC) Program- Medi-Cal

The Orange County Health Care Agency WIC program provides **Special Supplemental Nutrition Program for Women, Infants and Children (WIC)** and reaches most low-income pregnant women and children under 5, providing nutritious food, nutrition education, breastfeeding support and referrals to health and social services.

For assistance with coordination for referrals to WIC, which is a "carve out", please contact Noble's UM Department at (714) 947-8600.

For more information, please visit:

- WIC O.C. County: https://www.ochealthinfo.com/phs/about/family/nutrition/wic
- 211OC: https://www.211oc.org/

SUBJECT: Referral to WIC Policy # UM 28
DEPARTMENT: Utilization Management

Effective Date: February 2005
Last Revision Date: February 2007
Last Review: January 2023

SCOPE:

This policy applies to all Medi-Cal lines of business

PURPOSE:

To define the process for referring all eligible female members and young children to the Women, Infant and Children (WIC) Supplemental Food Program.

POLICY:

All members who are pregnant, breastfeeding, and postpartum women, infants and children under the age of five (5) will be referred to WIC.

To ensure that IPA members receive adequate nutrition during pregnancy and the postpartum period, each member's nutritional status shall be assessed:

- At the first prenatal visit or the CPSP visit
- At least once each trimester
- At least once during the postpartum period.

All primary care providers are to identify candidates for the program by performing nutritional assessments, as well as, hemoglobin and hematocrit tests on children under the age of five (5).

All members are eligible to receive WIC services to facilitate and encourage adequate nutrition during pregnancy and the postpartum period.

Test results reported on a CHDP form PM 160 for children or the CPSP assessment tool are to be provided to the WIC program with all referrals.

Referrals are to be documented in the member's medical record.

DEFINITION:

Women, Infant and Children Supplemental Food Program (WIC): A federal program that provides nutritional education and vouchers to purchase specific foods to eligible women and their infants and small children. Food vouchers offered include milk, eggs, cereal, juice, iron-fortified formula and infant cereals.

PROCEDURE:

A. At the time of the first prenatal visit/initial assessment with the pregnant member:
    a. A nutritional assessment will be completed;
    b. Recommendations specific to the member's individual dietary needs will be made to the member;
    c. The WIC referral form will be completed and given to the member.

B. PCPs are to perform a nutritional assessment, hemoglobin and hematocrit on young children to assess dietary intake. Results are to be documented:
    a. In the medical record
    b. On a PM 160 form.
    c. The WIC referral form will be completed, and a copy given to the member.

FORMS:

WIC Referral Form

REFERENCES:

Not applicable

QUALITY MANAGEMENT

HEALTHSMART MANAGEMENT SERVICES ORGANIZATION, INC.

2026 QUALITY MANAGEMENT POLICIES
TABLE OF CONTENTS

POLICY #	DESCRIPTION	#OF PAGES	LAST REVIEW DATE
QM Plan	Quality Management Plan	16 pages	January 2026
QM1	Quality Management Committee	4 pages	January 2026
QM2	Clinical Practice Guidelines	3 pages	January 2026
QM5	Member Satisfaction Surveys	2 pages	January **2026**
QM6	Provider Satisfaction Surveys	2 pages	January 2026
QM7	Correspondence/Dissemination of Information	2 pages	January 2026
QM8	Potential Quality of Care Issues	5 pages	January 2026
QM10	Access to Care Standards	9 pages	January 2026
QM11	Infection Control	4 pages	January 2026
QM12	Informed Consent	5 pages	January 2026
QM13	Oversight of Specialized DME Services	3 pages	January 2026
QM14	Cultural and Linguistics Service Standards and Monitoring	5 pages	January 2026
QM15	Interpréter & Translation Services	6 pages	January 2026
QM 16	Delegation Oversight for Facility Site Reviews	3 pages	January 2026
QM 17	Quality Improvement Projects	1 page	January 2026
QM 18	HEDIS Process and Reporting	2 pages	January 2026
QM19	Provider Preventable Conditions	2 pages	January 2026
QM 20	SNP Annual Face-to-Face	2 pages	January 2026

SUBJECT: Quality Management Committee **Policy #:** QM1
DEPARTMENT: Quality Management

Effective Date: January 1, 1998,
Last Revision Date: February 2007
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To outline the organizational process, format, and agenda of the Quality Management Committee (QMC) meeting.

POLICY:

The Quality Management Committee responsibilities include:

- Development and maintenance of the Quality Management Plan and Annual Quality Management Work Plan. Yearly review the effectiveness of the Quality Management Plan to revise as necessary.

- Review and evaluate the results of quality improvement activities, initiate necessary program improvement, recommend policy decision, and ensure follow-up, as appropriate.

- Select monitoring and evaluation topics and special studies that are relevant to the demographic and epidemiological characteristics of the group, which have a potential impact on the membership population served. Resources utilized may be demonstrated from utilization history including claims and encounter data. **When non-delegated**, the committee is responsible to take action to correct deficiencies sited by the health plan or agency.

- Utilize physician performance (peer review) against health plan clinical practice guidelines that are based on scientific evidence. Methods are implemented to communicate the guidelines and individual/group performance to providers.

- Review and evaluate potential quality issues through a peer review process to identify issues of quality of care and service up to and including sanctioning.

- Ensure that information and findings of quality management activities are used to detect trends, patterns of performance or potential problems and implement correction action where necessary.

- Ensure that the necessary information is communicated to appropriate individuals, departments, providers, and/or institutions when problems or opportunities to improve care and service are identified.

- Review, necessary research, implementation of necessary action and response of any and all grievances filed.

- Allocation of resources to activities that will have the greatest potential impact on the care and service provided to members, employers, and providers.

- Reporting of quality improvement activities in Provider Quality Profiles.

- Credentialing and recredentialing activities.

- Quarterly reporting of activities to all contracted health plans. Reporting to the Board of Directors.

A Quality Management Committee will convene at least quarterly or more frequently if necessary. Active participation on the committee includes consistent meeting attendance, involvement in discussion of agenda items, establishment of clinical practice guidelines, selection of monitoring measures used to assess performance and studies, analyzing results, and assisting in follow up activities and problem resolution as requested by the committee.

QM Committee Membership – The Quality Management Committee will consist of voting members and non-voting members. Members of the committee will be chosen for a two-year term. The chairperson/or designee will facilitate each meeting. A quorum of no less than three (3) voting members is required in attendance at each meeting.

Voting Rights/Quorum – All physicians with the exclusion of guests are voting members of the QMC. Voting members include the QM Chairperson, Medical Director, two (2) Primary Care Physicians, and one (1) Specialty Care Physician. The non-voting members may include UM Manager/UM Coordinator, Concurrent Review Nurse/Case Manager, Credentialing Manager and Manager of Member Services.

Minutes - A consistent format of minutes will be reviewed and approved by the QMC. Recorded separate from other committee agendas, the minutes will be maintained in a binder organized by the most recent date. Minutes of previous meetings will be made available for health plans that request a review. Minutes and other confidential documents may not be removed from the UM office, nor reproduced in any manner and will be kept in a locked area.

Guest Attendees **-** Upon request and with advance notice, guests including health plan employees may be permitted to attend the portion of the QMC that pertains to its business. Confidentiality statements will be signed and kept on file.

Confidentiality – All QMC Minutes, documentation, records, and proceedings shall be confidential as defined in Section 1157 of the California Evidence Code. The QMC Chairperson is responsible for ensuring that a current statement of confidentiality is on file for all who attend the meetings. This includes all voting and non-voting members and guests.

Conflict of Interest – The QMC Chairperson is responsible for ensuring that a current statement regarding conflict of interest is on file for all voting members.

Agenda - The QMC has the responsibility to ensure that appointed responsible parties follow up the agenda items, discussions, and recommended actions. The agenda activity may include one-time announcements, issues for immediate action, one-time referral decisions, ongoing case review, continuous monitoring, report review, provider education, medical and administrative policies and procedure and special projects. The recommended actions will remain open until resolution and goals are met.

Information included under the agenda items includes, but is not limited to:

1. Active discussions of quality improvement issues
2. Analysis of results of quality activities
3. Establishment/approval of clinical practice guidelines
4. Credentialing and Recredentialing activities
5. Peer Review activities
6. Recommendations, actions and follow up of issues identified regarding aspects of care and performance measures.
7. Case reviews
8. Grievances/Appeals
9. Provider Development as related to QM.
    - Medical policies/criteria
    - Study presentation & Corrective Action Plans
10. Reports to/from Utilization Management
    - Potential Quality Issues & Risk Issues
    - Provider & Member Satisfaction Surveys

DEFINITIONS:
Not applicable

PROCEDURE:

1. The QM Committee will meet in a confidential setting.

2. The QM Director will prepare the agenda and documents for review and record the minutes. The QM Chairperson is responsible for ensuring all QM Committee responsibilities occur timely.

3. The minutes will follow the agenda items with summarization of discussion, action & follow up.

4. All documents or handouts will be stamped “Confidential” or will include the phrase “Prepared for Quality Management Committee”.

5. Corrective action requiring peer review or potential quality issues will be noted in the provider profile.

6. The person who prepared the minutes will sign them for the date prepared. The chairperson will sign the minutes after committee approval.

7. The Quality Committee can call a special meeting at any time to address any urgent issues but must maintain a quorum for any decision-making.

FORMS:
None required.

REFERENCES:
Not applicable

SUBJECT: Clinical Practice Guidelines **Policy #:** QM2
DEPARTMENT: Quality Management

Effective Date: August 5, 1998
Last Revision Date: June 20th 2026
Last Review: June 2026

SCOPE:

This policy applies to all lines of business including the Special Needs Plan members.

PURPOSE:

To provide a method of systematically developing guidelines to assist providers and members to make decisions about appropriate healthcare for specific clinical circumstances. To assess the appropriateness of specific healthcare decisions, services and outcomes and provide methods or instruments to monitor and evaluate the extent to which the action of a provider conforms to clinical practice guidelines, medical review criteria and/or standards of quality to provide optimum clinical outcomes.

POLICY:

Selection of topics for guideline development will consider high volume, high-risk services, and those with potential for reducing clinically significant and unexplained variations in services and procedures. The information selected will be used in determining prevention, diagnosis, treatment, management, or outcomes related to the clinical condition and the cost of the condition to all payers, including members.

The Quality Management Committee (QM) is responsible to arrange for development, periodic review and updating of Clinical Practice Guidelines that may be used by providers to determine how specific conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed.

The QM Committee may appoint multidisciplinary subcommittees to develop guidelines and criteria. These subcommittees should have representation consistent with services provided and provider panel membership.

The guidelines include acute and chronic care services that are relevant to the enrolled membership. Based on the guidelines produced, the QM Committee develops medical criteria and performance measures for the monitoring and evaluation of care provided to the members.

Criteria is based upon established national guidelines, where available, scientific literature and prudent practice. Guidelines are based upon reasonable medical evidence. Guidelines are peer reviewed and developed by consensus.

Guidelines are reviewed at least every two years and revised, if necessary, to ensure that they are consistent with current literature and national guidelines as well as the outcomes and experience of the IPA.

Performance is measured against at least two guidelines on an annual basis. Guidelines that are relevant to the IPA enrolled membership are preferentially selected.

Guidelines are presented to the providers as they are developed and/or revised through educational sessions, mailings, and updates to provider manuals.

The Quality Management Committee monitors and evaluates the consistency with which the providers follow the guidelines. This may be defined through studies, Risk and Utilization Management reporting, Member and Provider Services department reports and applicable QM reporting.

DEFINITIONS:

Clinical Practice Guidelines: Quality improving strategies that define practice questions, identify decision options and outcomes; explicitly identify the best evidence about prevention, diagnosis, prognosis, therapy, harm and cost-effectiveness; and explicitly identify decision points at which the evidence needs to be integrated with individual clinical experience in deciding a course of action.

Special Need Plan [SNP]: A program of health care, services, and management for members that are dually eligible for Medicare and Medicaid benefits and services or institutionalized or institutional equivalent residing in the community or having certain CMS-approved severe or disabling chronic conditions.

PROCEDURE:

A. The QM Committee will clearly define the major questions regarding the clinical condition to be addressed, including the desired outcome as well as potential variation in outcomes.

B. Scientific data for each question will be reviewed and analyzed. Clinical benefits and potential adverse effects of each intervention will be assessed.

C. A review of estimates of important member outcomes for each intervention being considered will be performed.

D. A review of current and potential healthcare costs associated with the guideline will also be performed. When cost information is available, the committee may provide costs of alternative strategies for the prevention, diagnosis, treatment, and management of the condition.

E. The committee will invite information and comments on guidelines from other providers within the scope of clinical data being evaluated.

F. A draft guideline will be prepared and brought to committee for Peer Review in a format that is appropriate for use by the providers.

G. After approval by the committee, the guidelines will be distributed to all providers.

H. The committee will monitor and evaluate the outcome and appropriateness of use of the guidelines and revise where indicated. The data collected will also be analyzed to detect under or over utilization and evaluate continuity of care.

I. The QI Committee will elect a Peer Review Committee to evaluate appropriateness of use of clinical practice guidelines. The Peer Review Committee will perform a Medical Record review to identify evidence of appropriate application of guidelines. The Peer Review Committee may make recommendations back to the Provider, request corrective action and/or assess reasons why guidelines were not followed. The Peer Review Committee will report findings back to the QI Committee with

results of findings, issues identified, barriers and reasons why the guidelines could not be met. The QI Committee will evaluate the findings and assess if additional intervention is needed including but not limited to, follow-up review of provider records or additional revision of guidelines.

a) If a modification to an internal guideline is indicated, the QI Committee will recommend changes. If there is an issue with compliance with the Preventive Health CPGs that are national guidelines, the compliance issue will be addressed with the provider directly through a CAP process and monitor.

FORMS:
None required.

REFERENCES:
Not applicable

SUBJECT: Member Satisfaction Surveys **Policy #:** QM5
DEPARTMENT: Quality Management/Member Services

Effective date: January 1, 1998
Last Revision Date: November 14, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

The purpose of the survey is to identify perceived problems in quality, availability and accessibility of care, satisfaction with care and service [non-behavioral health and behavioral health], and reasons for the member's use of out-of-plan providers. The data from the survey will be used to identify sources of dissatisfaction, develop corrective action plans, and evaluate the effects of the corrective action.

POLICY:

Member Satisfaction Surveys will be conducted annually utilizing providers (PCP) that have a 300+ membership. Members will be randomly chosen. Member Satisfaction Surveys are conducted following the NCQA (National Committee for Quality Assurance) guidelines.

The survey will assess the following elements:

- Satisfaction with non-behavioral and behavioral health care provided.
- Waiting time for scheduled appointments
- Access to Primary Care and Specialist physicians
- After Hours Access to care
- Cultural & Linguistics needs

IPAs with low membership may elect to do a random sampling of membership from each PCP or elect to monitor member satisfaction through the quality review of grievances and complaints, etc.

Surveys will be made available in the IPA's threshold languages. All attempts will be made to provide the survey in the individual member's language when their language is separate from the threshold language of the IPA. The member may request free interpreting services to complete the survey.

An Attestation will accompany the original interpreted survey copies to ensure quality and completeness of interpretation.

For satisfaction with the Case Management and/or the Behavioral Health process, the IPA may elect to perform a verbal survey upon closure of the member's case to assess member satisfaction with the Case Management and interventions.

For evaluation of member satisfaction with telephone access to the MSO, the member services manager will review recorded calls to assess timeliness and accuracy of information provided and opportunities for training and improvement.

For plan's who perform Member Satisfaction Surveys, the UM & QI Committee will review the results and implement corrective action as required. Corrective action may include but is not limited to, education to providers on improving member satisfaction and direct on-site education with PCP office where identified.

Annually a report of findings will be sent to the QM Committee with corrective action plan and re-review to ensure implementation.

DEFINITIONS:

Annual: Annual is defined as at least every 12 months with a two-month grace period (14 months).

PROCEDURE:

A. The Member Satisfaction Survey may be randomly mailed to members Via U.S. mail with a self-stamped return envelope enclosed. Surveys may also be distributed at the PCPs office.

B. All data received is reviewed to ensure validity and reliability.

C. A Summary of Findings is completed using the previous year(s) findings for comparison of improvement.

D. The Summary is forwarded to QM Committee meetings for review. Based on the results of the survey, a corrective action plan will be implemented and monitored through subsequent member surveys.

E. The UM Committee will review the final results to address any findings related to the UM process or activities.

F. The Primary Care Providers will be notified of the results of the survey. According to the issues identified, provider office in-services, provider education meetings, etc. may be performed, as planned by the QM Committee.

FORMS:
Member Satisfaction Survey

REFERENCES:
NCQA QI6

SUBJECT: Provider Satisfaction Surveys **Policy #:** QM6
DEPARTMENT: Quality Management/Member Services

Effective Date: January 1, 1998
Last Revision Date: November 14, 2018
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

The purpose of the survey is to identify opportunities for improvement involving the delivery of the services to the MD/IPA's contracted physician providers and to identify areas that may require further study.

POLICY:

Provider Satisfaction Surveys will be conducted annually to all PCPs and high-volume specialists. Provider Satisfaction Surveys are conducted following the NCQA (National Committee for Quality Assurance) guidelines.

The survey will assess the following elements:

- Satisfaction with IPA/MSO
- Satisfaction with Provider Services Department
- Satisfaction with Claims Department
- Satisfaction with UM Department
- Satisfaction with contracted ancillary providers

The Provider Satisfaction Survey is set up on a 4-point scale as to the physician's agreement or disagreement with the statements regarding services that are provided to them by the IPA/MSO. They are rated as Very Satisfied, Satisfied or Not Satisfied

DEFINITIONS:

MSO: Management Services Organization. Provide administrative services such as claims payment, utilization review and member services for independent physician's associations.

NCQA: National Committee for Quality Assurance: a private organization dedicated to improving healthcare quality. It provides standardized, objective information for and about health care agencies.

Annual: Annual is defined as at least every 12 months with a two-month grace period (14 months).

PROCEDURE:

1. The PCP Satisfaction Survey is faxed and/or mail to all PCPs and high-volume specialists on an annually basis.

2. All data received is reviewed to ensure validity and reliability.

3. A Summary of Findings is completed using the previous year(s) findings in comparison of improvement.

4. The Summary is forwarded to the QM Committee meetings for review. Based on the results of the survey, a corrective action plan will be implemented and monitored through subsequent provider surveys.

5. The QM Committee will forward to the UM Committee a copy of the Summary of Findings for review as it relates to the UM Process. Intervention and follow-up, if necessary, will occur.

6. The Summary of Findings will also be distributed to the managers of each department where deficiencies are noted, to further ensure plans for corrective action.

7. The providers will be notified of the results of the survey.

FORMS:
None required.

REFERENCES:
Not applicable

SUBJECT: Provider Satisfaction Surveys **Policy #:** QM6
DEPARTMENT: Quality Management/Member Services

Effective Date: January 1, 1998
Last Revision Date: November 14,
Last Review: 2018 January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

The purpose of the survey is to identify opportunities for improvement involving the delivery of the services to the MD/IPA's contracted physician providers and to identify areas that may require further study.

POLICY:

Provider Satisfaction Surveys will be conducted annually to all PCPs and high-volume specialists. Provider Satisfaction Surveys are conducted following the NCQA (National Committee for Quality Assurance) guidelines.

The survey will assess the following elements:

- Satisfaction with IPA/MSO
- Satisfaction with Provider Services Department
- Satisfaction with Claims Department
- Satisfaction with UM Department
- Satisfaction with contracted ancillary providers

The Provider Satisfaction Survey is set up on a 4-point scale as to the physician's agreement or disagreement with the statements regarding services that are provided to them by the IPA/MSO. They are rated as Very Satisfied, Satisfied or Not Satisfied

DEFINITIONS:

MSO: Management Services Organization. Provide administrative services such as claims payment, utilization review and member services for independent physician's associations.

NCQA: National Committee for Quality Assurance: a private organization dedicated to improving healthcare quality. It provides standardized, objective information for and about health care agencies.

Annual: Annual is defined as at least every 12 months with a two-month grace period (14 months).

PROCEDURE:

1. The PCP Satisfaction Survey is faxed and/or mail to all PCPs and high-volume specialists on an annually basis.

2. All data received is reviewed to ensure validity and reliability.

3. A Summary of Findings is completed using the previous year(s) findings in comparison of improvement.

4. The Summary is forwarded to the QM Committee meetings for review. Based on the results of the survey, a corrective action plan will be implemented and monitored through subsequent provider surveys.

5. The QM Committee will forward to the UM Committee a copy of the Summary of Findings for review as it relates to the UM Process. Intervention and follow-up, if necessary, will occur.

6. The Summary of Findings will also be distributed to the managers of each department where deficiencies are noted, to further ensure plans for corrective action.

7. The providers will be notified of the results of the survey.

FORMS:
None required.

REFERENCES:
Not applicable

SUBJECT: Potential Quality of Care Issues **Policy #:** QM8
DEPARTMENT: Quality Management

Effective Date: February 2005
Last Revision Date: September 2, 2020
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define the process for review and disposition of potential Quality of Care (QOC) issues.

POLICY:

Quality of Care issues may include but is not limited to: Critical Incidents, such as member is exposed to abuse, neglect or exploitation, a serious, life threatening, medical event that requires immediate emergency evaluation by medical professional(s), the disappearance of the member, a suicide attempt by the member, death of member, and restraint or seclusion of the member; Sentinel Events as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness; or Provider Preventable Conditions as defined in P&P QM19.

All departments, and contracted health plans that delegate the case review process shall refer potential QOC issues to the Quality Management (QM) Department immediately upon identification of potential issue. When not delegated Quality Management, the QI Manager will forward all QOC issues to the Health Plan within 24 hours or immediately if life threatening.

The QM Department shall conduct a review of all potential QOC issues by requesting all pertinent medical records from providers and conducting a case review investigation.

All peer review documentation, records and proceedings will be confidential as defined by Section 1157 of the California Evidence Code.

Cases identified as having a potential QOC issue may be referred, if necessary, to the Medical Director and/or the QI Committee for further evaluation and action.

Findings of case reviews shall be reported to health plans that delegate this process to the IPA.
Relevant information from all Case Reviews shall be trended by the QM Department, whether QOC issues were identified or not.

The QM Department shall prepare a summary report of all QM case activities and submit the report for review to the QI Committee. The chairperson of the QM Committee shall report activities/findings to the IPA Board of Directors.

DEFINITIONS:

Case Review: Review and disposition of concerns referred to the QM Department for potential QOC issues.

Facility: An entity where a member accesses health care service.

Management Services Organization (MSO): Management Company for medical groups and/or IPAs.

Provider: Any individual, partnership, clinic, group, association, corporation, institution, or public agency designated in Title 22, Section 51051, which meets applicable standards for participation with the Medi-Cal program.

Quality of Care (QOC): The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Critical Incidents Definitions**:**

Abuse:

- Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any member.
- Knowing, reckless, or intentional acts or failures to act which cause injury or death or which placed that member at risk of injury or death.
- Rape or sexual assault.
- Corporal punishment or striking.
- Unauthorized use or the use of excessive force in the placement of bodily restraints; and
- Use of bodily or chemical restraints, which is not in compliance with federal or state laws and administrative regulations.

Neglect:

- Inability of a member to secure food, shelter, clothing, health care, or services necessary to maintain his/her mental and physical health.
- Failure by any caretaker to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care.
- Negligent act or omission by any caretaker which causes injury or death or which places that member at risk of injury or death.
- Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an appropriate individual program or treatment plan.
- Failure by any caretaker to provide adequate nutrition, clothing, or healthcare.
- Failure by any caretaker to provide a safe environment; and
- Failure by any caretaker to provide adequate numbers of appropriately trained staff in its provision of care and services.

Exploitation:

- An act committed by a caretaker or relative of, or any person in a fiduciary relationship with a member, means:
- The taking or misuse of property or resources by means of undue influence, breach of fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means.
- The use of the services without just compensation; or
- The use of a member for the entertainment or sexual gratification of others under circumstances that cause degradation, humiliation, or mental anguish.

A Serious Life Threatening, Medical Event That Requires Immediate Emergency Evaluation by a Medical Professional:

- Admission of an individual to a hospital or psychiatric facility or the provision of emergency medical services (treatment by EMS) that results in medical care which is unanticipated and/or unscheduled for the individual and which would not routinely be provided by a primary care provider.

Disappearance/Missing Member (Missing Person):

- Whenever there is police contact regarding a missing person, regardless of the amount of time the person was missing.

Suicide Attempt:

- The intentional attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include verbal suicidal threats by a member receiving services.

Unexpected Death:

- The death of an individual is reported, unexpected death that was not result of a chronic disease process.

Restraints or Seclusion:

- Every time an individual is restrained, it is:
- Personal (the application of pressure, except physical guidance or promoting of brief duration that restricts the free movement of part or all an individual's body).
- Mechanical (the use of a device that restricts the free movement of part or all of an individual's body. Such devises include: an anklet, a wristlet, a camisole, a helmet with fasteners, a muff with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt or one used for medical treatment, such as a helmet used to prevent injury during a seizure). It also means to cause a device that allows for free movement to be unusable. Such as locking a wheelchair or not allowing an individual access to technology.
- Chemical (the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means to control an individual's activity and which is not a standard treatment for the individual's medical or psychiatric condition).
- Seclusion: involuntary confinement in a room where the member is physically prevented from leaving.
- Isolation: forced separation or failure to include the member in the social surroundings of the setting or community.

PROCEDURE:

A. Case Identification

1. Members, staff, health plans or providers may identify potential QOC events. Areas such as concurrent, utilization review process, case management process, grievances or encounter data evaluation will be utilized to identify these events.

2. All case identification originating within IPA will be sent, confidentially, to the QM Department on a completed QM/Risk Management Referral Form (attached). Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

3. Where not delegated, Quality Management, the QI Manager will forward all QOC issues to the Health Plan within 24 hours or immediately if life threatening.; or when delegated:

4. Within seven (7) days of receipt of a referral, the QM Department will send out an acknowledgement to the referring party (attached).

B. Delegated Review Process

1. Copies of pertinent medical records from facilities where medical services were rendered will be requested in writing (form letter attached). Facilities are expected to submit such records to IPA within 14 calendar days.

2. If a facility or provider fails to respond within the required timeframe:

    a. A second letter will be sent requesting a response within seven (7) days. This letter will be sent 14 days after the initial request.

3. If, after seven (7) days, there is no response to the second letter, a third letter will be sent requesting an immediate response. This letter will be copied to supervisory staff of the provider or facility.

4. If there is no response to the third letter within 24 hours, IPA may send a courier to retrieve the records. The facility or the provider may be notified by fax or in writing of this action.

5. The QM Department may telephone the appropriate contact person to expedite the receipt of the requested records or review findings.

6. IPA will complete its review within 30 days of receipt of the review response or records.

7. If a request for review of a QOC issue is received from a health plan that delegates the review process to IPA, IPA will:

    a. Submit the findings of its review, in writing, to the health plan within 30 days of receipt of the request OR

    b. Notify the health plan of any delay in obtaining pertinent medical records within 30 days of receipt of the request.

8. At the time of notification to the health plan, a written corrective action plan will also be submitted, if appropriate.

C. Evaluation of QOC Issue

1. Once pertinent medical records are received, they will be evaluated by the QM Department to determine whether a QOC issue exists.

2. The findings will then be presented to the Medical Director for review.

3. If no QOC issue is identified, no further action will occur, and the case will be closed by the Medical Director.

4. If a QOC issue is identified, the Medical Director will assign a level of severity (See Case Review Summary Form) and present the case to the QM Committee.

5. The QM Committee may recommend an action as described in Case Review Summary Form or may request further review of the case by a multidisciplinary team, or a medical specialist.

6. Results of that review will be presented to the QM Committee for final action.

7. Actions may include a written CAP; education; and reduction of members, up to and including suspension or termination of a provider. (see CR 5 – Reduction, Suspension or Termination of Provider Status).

D. Follow-up Actions

1. A summary report of all Case Reviews, including the conclusions and recommendations of the Medical Director and other reviewers shall be submitted to the IPA Board of Directors.

2. The QM Department shall follow up on all actions recommended by the QM Committee and/or the Board of Directors.

3. All potential QOC issues and sanctions will be noted in the provider profile.

4. If a change in provider is necessary for members, the Quality Management Department will work with the Utilization Management Department and the Member Services Department to ensure a smooth transition of care.

FORMS:

QM/Risk Management Form
Medical Records Request (sample letter)
Acknowledgement memo to the referring party (internal form)
Case Review Summary Form

REFERENCE:

IPA Quality Management Program
Section 1157 of the California Evidence Code, Title 22, Section 51051

SUBJECT: Access to Care Standards **Policy #:** QM 10
DEPARTMENT: Quality Improvement

Effective Date: January 1998
Last Revision Date: December 20th, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure that all members have adequate access to health care and receive services in a timely non-discriminatory manner.

POLICY:

All members shall have equal access to health care in a timely manner.

All providers should have a scheduling system in place meeting all access standards. Missed appointments shall be documented in the member's file. Providers will make 3 attempts to outreach to members who failed an appointment to reschedule appointments.

All providers are contractually required to notify the IPA of any changes in availability, telephone and facsimile number, or location of office within 30 days prior to effective date of change.

Members are encouraged to appropriately use the "911" emergency response system when they have an emergency medical condition which requires an emergency response.

Primary Care Providers will not discriminate against members relative to their health plan coverage in comparison to others.

An RN, Physician Assistant or Nurse Practitioner or the physician/provider may only perform telephone triage directly.

Quality Improvement will monitor access standards including accessibility, scheduling, wait times and member complaints, ongoing and formally on a yearly basis through the Access Study process. All Primary Care Providers and High-Volume Specialists will participate in the study with the goal being that all providers meet 100% of the access standards. For those providers not meeting the access standards, a corrective action plan will be put in place and monitored by Quality Improvement. A random re-audit will be performed to ensure correction.

Results from the study will be entered into the provider profile for re-credentialing purposes.

DEFINITIONS[i]:

Advanced Access means the provision, by an individual provider, or by the medical group or independent practice association to which a member is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day.

Ancillary service includes, but is not limited to, providers of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, and home-health service providers" [as defined by H&S Code Section 1323(e)(1)].

Appointment waiting time means the time from the initial request for health care services by a member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.

Discrimination: Treating a member differently from any other privately or publicly covered patient in the provision of a covered service or accessibility on the basis that the member is eligible, or on the basis of race, color, creed, religion, ancestry, martial status, sexual orientation, national origin, age, sex, language, or mental or physical disability.

Emergency Medical Condition: A medical condition, which 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:

1. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or
2. Serious impairment to bodily function; or
3. Serious dysfunction of any body part or organ.

Emergency Services: Inpatient or Outpatient covered services furnished by a qualified provider, which are needed to evaluate or stabilize an Emergency Medical Condition, including at a minimum, a Medical Screening Examination to determine the presence or absence of an Emergency Medical Condition.

Provider: means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services [as defined by H&S Code Section 1345(i)].

Preventive care: means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full-service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.

Routine Primary Care: The evaluation and treatment of non-acute problems for new and established patients.

Specialist is defined as a residency-trained, board-certified, or board-eligible licensed practitioner who completed advanced training in a field recognized by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA).

Non-Physician Mental Health Providers: are Psychologist, Licensed Clinical Social Worker, and Marriage and Family Therapist.

Cont. DEFINITIONS:

Telemedicine: means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (real-time or near real-time two-way transfer of medical data and information). Neither a telephone conversation nor an electronic mail message between a health care practitioner and member constitutes telemedicine for the purposes of this policy and procedure.

Triage or Screening means the assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

Triage or screening waiting time means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.

Urgent Care Services: means health care for a condition which requires prompt attention when the enrollee's condition is such that the member faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function (consistent with subsection (h)(2) of Section 1367.01 of the Act).

PROCEDURE:

A. ACCESS STANDARDS:

Commercial Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent Care appointments for Primary Care (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)[1]	Not to exceed 15 minutes

[1] As per DMHC Access & Availability Technical Assistance Guide Section AA-05, 1.5, and T28 CCR §1300.67.2 (f) & 1300.67.2.1(c)(13) & ICE Provider Appointment Access Policy & Procedure Template

Behavioral Health Emergent & Non-Emergent Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Non-urgent appointments with a physician mental health care provider	Must offer the appointment within 10 business days of request
Non-Urgent Care appointments with a non-physician mental health care provider [i.e. Psychologist, Licensed Clinical Social Worker, and Marriage and Family Therapist]	Must offer the appointment within 10 business days of request. Appointment for follow-up routine care with a non-physician behavioral health care provider within twenty (20) calendar days of initial visit for a specific condition.
Urgent Care appointments	Must offer the appointment within 48 hours of request
Access to Care for Non-Life-Threatening Emergency	Within 6 hours
Access to Life-Threatening Emergency Care	Immediately
Access to Follow Up Care After Hospitalization for mental illness	Must Provide Both: One follow-up encounter with a mental health provider within 7 calendar days after discharge, plus One follow-up encounter with a mental health provider within 30 calendar days after discharge

(These standards do not apply where members have direct access to Behavioral Health Services or sites.)

Medi-Cal Non-Emergent Medical Appointment Access Standards

Access Measure	Time-Elapsed Standard
Access to PCP or designee	24 hours a day, 7 days a week
Non-urgent Care appointments for Primary Care (PCP Regular and Routine, excludes physicals and wellness checks)	Must offer the appointment within 7 business days of request
Adult physical exams and wellness checks	Must offer the appointment within 30 calendar days of request
Non-urgent appointments with Specialist physicians (SCP Regular and Routine)	Must offer the appointment within 15 business days of request
Urgent Care appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner, Physician's Assistant in office)	Must offer the appointment within 24 hours of request
Urgent Care appointments that require prior authorization (SCP)	Must offer appointment within 96 hours of request
First Prenatal Visit	Must offer the appointment within 5 business days of request: Non-urgent 3rd trimester and high risk – within 3 calendar days
Child physical exam and wellness checks with PCP	Must offer the appointment within 10 business days of request
Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of request
Initial Health Assessment (members age 18 months and older)	Must be completed within 120 calendar days of

Access Measure	Time-Elapsed Standard
	enrollment
Initial Health Assessment (members age 18 months and younger)	Must be completed within 60 calendar days of enrollment
Sensitive Services Appointment	Preferably within 24 hours but no later than 48 hours

Medicare/Medicare Advantage Non-Emergent Medical Appointment Access Standards

Appointment Type	Time-Elapsed Standard
Access to PCP or designee	24 hours a day, 7 days a week
Adult physical exams and wellness checks	Must offer the appointment within 30 calendar days of request
Non-urgent Care appointments for Primary Care (PCP)	Must offer the appointment within 7 Business Days of the request
Non-urgent Care appointments with Specialist physicians (SCP)	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within96 hours of request
Non-urgent Care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within15 Business Days of the request
In-office wait time for scheduled appointments (PCP and SCP)[2]	Not to exceed 15 minutes
Non-Physicians Mental Health Provider	Must offer the appointment within 10 Business Days of the request
After Hours and Emergent Care	24 hours a day, 7 days a week
Member Services, by telephone	During normal business hours

EXCEPTIONS:

Preventive Care Services and Periodic Follow Up Care:
Preventive care services and periodic follow up care including but not limited to, standing referrals to specialists or chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Advance Direct Access:
A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance direct access to primary care appointments as defined herein.

[2] As per DMHC Access & Availability Technical Assistance Guide Section AA-05, 1.5, and T28 CCR §1300.67.2 (f) & 1300.67.2.1(c)(13) & ICE Provider Appointment Access Policy & Procedure Template

Appointment Rescheduling:
When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending Appointment Waiting Time:
The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

Interpreter Services
Interpreter services required by Section 1367.04 of the California Health & Safety Code and Section 1300.67.04 of Title 28 of the California Code of Regulations shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. *See Interpreting Services P&P QM15.*

Prior Authorization Processes
Prior authorization processes are to be completed in a manner that assures the provision of covered health care services to members in a timely manner appropriate for the member's condition and in compliance with the requirements of the time-elapsed access standards. *See ICE Timeliness Standards for Referral timeliness Requirement. For LA Care Health Plan – See LA Care's Timeliness Requirements.*

Shortage of Providers
To ensure timely access to covered health care services as required in this policy, where there is a shortage of one or more types of providers, providers are required to refer members to available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the member's health needs. Furthermore, providers shall arrange for the provision of specialty services from specialists outside the provider's contracted network if unavailable within the network, when medically necessary for the member's condition.

Member costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating a member's preference to wait for a later appointment from a specific contracted provider.

Triage &/or Screening
All Providers shall provide or arrange for the provision of 24/7 triage or screening services by telephone and ensure that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage or screening wait time does not exceed 30 minutes.

The Provider must at a minimum maintain a procedure for triaging or screening member telephone calls, which shall include the 24/7 employment of a telephone answering machine/service/or office staff that will inform the caller:

a. Regarding the length of wait for a return call from the provider (not to exceed 30 minutes); and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

If a member calls after hours or on a weekend for a possible medical emergency, the Provider is held liable for authorization of or referral to, emergency care given by the answering service. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room."

- Answering service/office staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical professional. Unlicensed telephone staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

- Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional.

- The answering service should document all calls.

Telemedicine

To the extent that telemedicine services are appropriately provided as defined per Section 2290.5(a) of the Business & Professions Code, these services shall be considered in determining compliance with the access standards hereby established.

Prior to the delivery of health care via telemedicine, the provider must obtain verbal and written informed consent from the member or the member's legal representative. The informed consent procedure shall ensure that at least all the following information is given to the member or the member's legal representative verbally and in writing:

1. The member or the member's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the member or the member's legal representative would otherwise be entitled.
2. A description of the potential risks, consequences, and benefits of telemedicine.
3. All existing confidentiality protections apply.
4. All existing laws regarding member access to medical information and copies of medical records apply.
5. Dissemination of any member identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the member.

A member or the member's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the member or the member's legal representative understands the written information provided and that this information has been discussed with the health care practitioner, or his or her designee. The written consent statement signed by the member or the member's legal representative shall become part of the member's medical record.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

For Medi-Cal Managed Care, all telehealth providers must comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.

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 via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers.

B. TELEPHONE ACCESS STANDARDS:

1. Non-Emergent member telephone messages to be returned within 24 hours.

2. Urgent telephone calls must be returned by the physician or his "on-call" coverage immediately.

3. Members are encouraged to appropriately use the "911" emergency response system when they have an emergency medical condition which requires an emergency response.

4. Clinical advice can only be provided by appropriately qualified staff (i.e., physician, physician assistant, nurse practitioner or registered nurse.)

C. ACCESS MONITORING PROCEDURE:

1. The Member Services Department, on an ongoing basis, will monitor telephone access and member complaints regarding access to providers.
2. On an annual basis the Provider Services Department will conduct an Access Study Survey for contracted providers.

3. The Access study survey will monitor the Primary Care physicians, Specialists, Ancillary Providers, Behavioral Health Providers and Non-Mental Health providers, access, and availability to provide services to members. The appliable access standard timeframes are referenced in this policy.

4. On an annual basis, the Member Services and Provider Services departments will monitor telephone access by contacting provider offices during office hours and after hours via telephone with a list of scenarios for each criterion. Findings are recorded on the NCQA "Primary Care Provider/Specialist Tally Sheet".

5. All findings are forwarded to the Quality Improvement Committee for review, with a summary comparison of the previous year's findings, to monitor improvement or need for improvement. In some cases, the health plan may perform these studies and the group will review the plan's findings and address corrective action where identified.

6. Based on the results of the study, the Quality Improvement Committee may request corrective action to be implemented. Corrective Action may include, but is not limited to, In-service of Provider and office staff, increase medical staff/FTE's, developing of policy and procedure to meet Access Standards, Extend office hours, etc.

7. Wait Times are monitored through the Member Satisfaction Study.

8. Member Satisfaction Study results are reported to the Quality Improvement Committee.

D. IPA/MSO ACCESS STANDARDS:

1. Members and Providers can utilize a statewide toll-free number, 24 hours a day/ 7 days a week for telephonic assistance.

2. The MSO staff will be available at least 8 hours a day, during normal business hours for incoming and outgoing calls. All employees will identify themselves for each incoming and outgoing call.

3. For After hours coverage, the IPA and MSO will have an Answering Service or process to contact designated employees for urgent calls via pager/cell phone. Any Utilization Outpatient or Inpatient authorization activity will be directed to the IPA's Medical Director for approval and/or direction. Only a physician will give medical advice. All After-Hours calls will be logged and followed up on the next business day.

4. If a member contacts the MSO through a collect call process, the Staff member will accept the call to address the member's needs.

5. All reasonable efforts will be made to provide an interpreter on time to adequately assist with all questions and concerns.

FORMS:
Primary Care Provider/Specialist Tally Sheet.

REFERENCES:
NCQA QI5

[i] Cal Optima – Access to Health Care Policy# GG.1600

SUBJECT: Infection Control **Policy #:** QM 11
DEPARTMENT: Quality Management

Effective Date: February 2005
Last Revision Date: February 2007
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To provide a consistent method for managing contamination and cross-contamination within an ambulatory setting to help prevent the transmission of potentially infectious agents to members and staff.

POLICY:

All staff members in an ambulatory setting shall be trained in Infection Control so that they have a clear understanding of the proper protocols to protect themselves and members.

Staff shall utilize protective equipment (gown, gloves, mask, and goggles) to prevent exposure to blood and other potentially infectious materials.

Staff will follow Universal precautions, as defined by the Centers for Disease Control and Prevention (CDC) to assure that good isolation techniques are in practice.

All instruments, surfaces and waste will be handled properly, cleaned, sterilized, or disposed of using infection control precautions and techniques.

Staff will immediately report any possible exposure to a member or themselves to the physician in charge of the ambulatory setting.

DEFINITION:

Not Applicable

PROCEDURE:

A. Infectious Waste

1. Infectious waste must be handled and disposed of in accordance with all applicable state, county, and local health laws.

2. Infectious waste must be kept in rigid containers away from members, animals, and weather conditions.

3. Infectious waste must be kept separated from other waste.

4. Infectious waste must be transported to an off-site disposal facility by a hauler registered as a hazardous waste hauler.

5. Medical waste includes:

    a. Viral hazardous waste or sharps waste
    b. Waste produced because of the diagnosis, treatment or immunization of patients.

6. Biohazardous waste includes:
    a. Laboratory waste (human specimen cultures, production of bacteria, viruses, or spores; discarded live and attenuated vaccines and used culture dishes
    b. Waste containing microbiologic specimens was sent to a lab for analysis.
    c. Human surgery tissue that a physician suspect is infectious.
    d. Waste containing recognizable fluid blood products, especially those infected with communicable diseases.
    e. Bodily fluids from patients who are required to be isolated because of communicable diseases.

7. Sharp waste is any device with acute, rigid corners, edges or protrusions that might cut or pierce skin, such as hypodermic needles, blades, pipettes, and blood vials.

8. Containment and Storage

    a. Medical waste

    b. Use regular waste cans in all exam rooms.

    c. Use a biohazardous waste can in rooms where procedures are performed.
        1. Can must be rigid, step-on variety with a red plastic liner.
        2. Can must be labeled as Biohazardous.
        3. When full, the bag must be stored in a locked area.

    d. Employees must be trained in the handling and disposing of biohazardous waste and contaminated laundry.

    e. A training log must be maintained.

B. Universal Body Substance Precautions

1. All ambulatory staff will take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments during a procedure or during cleaning and disposal.

2. Needles should be disposed of in sharps containers, without recapping, bending or breaking.

3. Good hand washing technique should be followed.

    a. Soap or waterless antiseptic hand cleaners and towels are to be kept in all patient rooms and rest rooms.

    b. Hands are to be cleansed before and after patient contact.

c. Wash with soap and water for a minimum of 30 seconds or follow directions on waterless antiseptic hand cleaners.

4. Use appropriate protective equipment.

    a. Gown, mask, and eye protection when splashes of blood or body fluids are anticipated.

    b. Gloves for handling soiled surfaces or wounds.
        1. Wash hands and change gloves between patients.

5. Spills of blood or other potentially infectious agents should be cleaned with an EPA approved disinfectant or a one to ten (1:10) mixture of bleach and water.

6. Mouthpieces should be used for resuscitation and be kept in emergency kits.

C. Instrument Sterilization

1. All soiled instruments must be thoroughly cleaned, rinsed, dried and inspected for the presence of dried debris prior to sterilizing.

2. Cold Sterilization

    a. A solution used for cold sterilization must be able to kill HIV, Hepatitis B and TB organisms.

    b. Containers with sterilization solutions should be labeled with the name of the solution, date of activation and expiration.

        1. Follow manufacturer's instructions for determining the expiration dates. Solutions vary in expiration from 14 days to greater than 30 days.
        2. Containers should be checked for evaporation loss of solution.

    c. Completely submerge cleaned items in a disinfectant solution. Follow label instructions to determine the length of time required for complete sterilization.

    d. Do not add un-sterilized instruments to a tray containing instruments that are already sterile. To do so, the length of time for all instruments must be extended to account for the latest instruments added.

    e. Rinse items in sterile water prior to use

3. Steam Sterilization (Autoclave)

    a. Follow manufacturer's guidelines for loading, operation safety, and minimum time-temperature criteria.

    b. Wrap instruments following guidelines on wrapping materials.

c. Label each package with date of sterilization and contents if packaging material is not transparent.

d. Packages sterility is event related, not time related. Sterilized items are considered sterile until use unless an event causes contamination. Types of events: package becomes wet, or package is opened or damaged.

e. Monthly spore testing must be done on each autoclave. Follow manufacturer's guidelines for performing spore testing.

f. In the event of a positive spore testing result:

1. Discontinue use of autoclave
2. Report the problem.
3. Arrange for repair of the autoclave.
4. Remove from use all instruments sterilized since last negative spore test. Re-wash, wrap and sterilize once the autoclave has been repaired.

D. Isolation and Reporting Communicable Diseases

1. All sites must be able to isolate patients with potentially contagious conditions from other patients.

2. Once the patient leaves the area, the room utilized for isolation must be cleaned with an appropriate antiseptic cleaner.

3. Providers are to notify the local health department regarding any patient with a known or suspected communicable disease.

4. To report a known or suspected communicable disease call:

a. For Los Angeles County, call: 213-240-8117

b. For Orange County, call 714-834-8180

FORMS:

None

REFERENCES:

CDC
California Occupational and Safety Administration (CalOSHA)
Titles 8 and 22, California Code of Regulations

SUBJECT: Informed Consent **Policy#:** QM 12
DEPARTMENT: Quality Management

Effective Date: January 2005
Last Revision Date: May 24, 2007
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To establish guidelines within which IPA may provide sufficient information to the network's eligible members regarding their right to accept or deny any recommended medical procedure and to have sufficient information to make consent for medical treatment meaningful.

POLICY:

A member has the right to decide what will happen to their body when receiving medical care.

Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for medical treatment. Informed Consents are signed for operative and invasive procedures. Human sterilization requires DHS Consent Form 330. Signed authorization is documented in the medical record for release of medical information.

A legal guardian must make all medical decisions on behalf of incompetent members. If the physician or a court of competent jurisdiction determines that a member requires a representative other than a legal guardian to make medical decisions, that representative must be one of the following, in the order stated below:

1. Person designated under a Durable Power of Attorney for Health Care (DPAHC).
2. Conservator specifically authorized by a court to make health decisions.
3. Next of kin.
4. Any other surrogate designated consistent with applicable laws.
5. A person appointed by a court or if the member is a minor, someone lawfully authorized to represent the minor.

A representative may facilitate care or treatment decisions for a Medicare Advantage member who is incapable of doing so because of physical or mental limitations.

Physicians are responsible for providing patients with sufficient information in lay terms, so an informed decision can be made. All information must be disclosed that allows a reasonable person in the patient's position to accept or reject a recommended procedure.

DEFINITIONS:

Emancipated Minor: Persons under the age of 18 years are emancipated if they have entered into a valid

marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 1722.

Legal Guardian: A person who has the legal responsibility for providing the care and management of a person who is incapable, either due to age (very young or even very old, or to some other physical, mental or emotional impairment, of administering his or her own affairs.

Sensitive Services: Family Planning, HIV Testing, STD testing and treatment, Termination of Pregnancy.

Statutory requirement: Laws passed by state or federal legislatures.

PROCEDURE:

A. Appropriate use of consent forms:

1. Simple and common procedures such as blood test or urinalysis, do not require use of a consent form (except when required by law, such as for sensitive services).

2. Consent does not need to be obtained if an emergency exists.

3. A consent form is used in conjunction with a thorough discussion with the member in order to obtain informed consent for any surgical, special diagnostic or special therapeutic procedure or treatment, or when there is a statutory requirement.

4. Any member requiring translation services must be offered them.

5. Physicians must document in the member's medical record that the oral discussion leading to the consent took place.

6. Informed consent must be obtained in writing and must be signed by the member or legal representative.

7. Consent forms must include:
   a. Member's name.
   b. Physician's name.
   c. Name of the procedure to be performed.
   d. Authorization for a specified physician and assistants to perform a specified procedure.
   e. Written explanation of the nature of the procedure, expected benefits of the procedure, expected discomfort, complications or risks to the member, description of any alternative method of treatment and description of what will likely happen if the procedure is not performed.
   f. Member's signature or legal representative's signature along with a copy of the legal documents granting legal representation. A relative's signature, in the case of a documented existing medical emergency, does not need a court order.
   g. Date and time.
   h. Witness' signature.

8. Providers encountering difficulties in the areas of legal consent should seek legal counsel. This explanation does not supplant advice of counsel.

9. Members who change their mind regarding consent for a procedure or treatment are entitled to withdraw consent even after signing.

B. Medical Treatment or Procedures

Members must be informed before undergoing a procedure or treatment. Health care professionals must ensure that members have enough information to enable them to decide about treatment. Information is written on the consent form and a copy is given to the member. Choices of treatment are discussed with the member. Patient's attitudes vary on the amount of risk, pain, or even the amount of information they are prepared to accept. Members have the right to discuss these worries with the health care provider before signing an informed consent.

C. Sterilization Procedures

Members must be informed before undergoing sterilization procedures. Consent must be obtained. Sterilization performed because pregnancy would be life-threatening to the mother (therapeutic sterilizations) is included in this requirement. However, sterilization that is the unavoidable secondary result of a medical procedure and the procedure is not being done in order to achieve it, is not. Procedures that would ordinarily require consents are excluded if the member is already sterile.

1. Certification of Informed Consent for Reproductive Sterilization

The Consent Form PM330 provided by the Department of Health Services (DHS) in English and Spanish is the only form approved by DHS. The Consent Form (PM330) must be signed and dated by:

a. The person to be sterilized.

b. The interpreter (if one is used in the consent process);

c. The person who obtained the consent.

d. The physicians perform the sterilization.

e. By signing the Consent Form PM330, the person securing the consent certified too personally:

(i) Advise the person to be sterilized before that person has signed the consent form, that no federal benefits may be withdrawn because of a decision not to be sterilized.

(ii) Explain orally the requirements for informed consent as set forth on the Consent Form PM330 and as detailed in the Informed Consent Process Requirement discussion.

(iii) Determine to the best of your knowledge and belief that the person to be sterilized appeared mentally competent and knowingly and voluntarily consented.

2. Conditions Under Which Sterilization May be Performed.

Sterilization may be performed only if:

a. The member is age 21 at the time the consent is obtained.

b. The member is not mentally incompetent.

c. The member can understand informed consent.

d. The members are not institutionalized.

e. The member has voluntarily given informed consent in accordance with all prescribed requirements.

f. At least 30 days, not more than 180 days, have passed between the date of informed consent and the date of the sterilization. Please refer to the "Exceptions to Time Limitations" for information regarding the time requirements in the case of emergency abdominal surgery or premature delivery.

3. Exceptions to Time Limitations for Sterilization

Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if at least 72 hours have passed after the written informed consent to be sterilized was given and the written informed consent to be sterilized was given at least 30 days before the patient originally intended to be sterilized or the written informed consent was given at least 30 days before the expected date of delivery.

D. Informed Consent Process Requirements

The following criteria must be met for compliance with the informed consent process.

1. Conducted either by a physician or by the physicians' designee.

2. Suitable arrangements are made to ensure that the information is effectively communicated to the member who is deaf, blind, or otherwise disabled.

3. An interpreter is provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining the consent.

4. The member to be sterilized is permitted to choose a witness who is present when consent is obtained.

5. The sterilization operation is requested without fraud, duress, or undue influence.

E. Medical Record Documentation

1. There must be documentation in the progress notes of the patient's medical record that a discussion regarding the procedure or treatment has taken place, including the answers given to specific questions or concerns expressed by the patient.

2. The fact that the booklet and a copy of the consent form were given to the patient must also be noted.

3. The original signed consent form must be filed in the medical record.

4. A copy of the signed consent form must be given to the patient and a copy placed in the patient's medical record at the place where the service is performed (i.e., outpatient surgery center or hospital).

5. If the procedure is a hysterectomy, a copy of the informed consent form for hysterectomy must be placed in the medical record. The form is obtained from the hospital performing the procedure.

E. Office Documentation for Sterilization

All contracted providers are responsible for maintaining a log of all sterilization procedures performed. The sterilization log must indicate the patient's name, date of sterilization, and type of procedure performed.

FORMS:

General Consent Form
Sterilization Consent Form

REFERENCES:

None

SUBJECT: Oversight of Specialized DME Services **Policy #:** QM13
DEPARTMENT: Quality Management

Effective Date: February 2005
Last Revision Date: February 2007
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure that specialized services provided to members, via a DME vendor, meet all quality standards of the Department of Health Services and the Department of Managed Health Care

POLICY:

Where possible, IPA will utilize vendors who are contracted with health plans. If these vendors have had organizational/quality audits performed by a health plan, IPA will not be required to perform this oversight process.

All vendors who do not have a contract with any health plan will have a pre-contractual site visit by IPA.

The Utilization Management Department will oversee the referral authorization process. (see P&P UM4 – Referral Authorization Process)

The Case Management department will obtain approved referrals from the UM Department and will order and monitor all requests for specialized DME.

Monitoring of the vendor's quality will consist of review of their quality program, member satisfaction surveys, tracking and trending of member grievances (see P&P Member Services Grievances) and review of monthly reports.

DEFINITIONS:

Durable medical equipment (DME): Medical equipment such as wheelchairs, walkers, hospital beds, canes, commodes and other equipment that could be used by one (1) person and used again by another person (i.e. not single use equipment).

Seating Clinic: A contracted entity composed of a multidisciplinary team, led by a physical therapist, that performs evaluations of a member's needs for custom seating systems, recommends appropriate systems, and provides fitting for this system.

Specialized DME: Medical equipment such as electric wheelchairs, and custom wheelchairs

PROCEDURE:

A. Requests:

1. All requests for specialized DME will be reviewed for appropriateness and benefit coverage by the Utilization Management department following P&P UM 4, Referral Authorization Process.

2. Once a request for a specialized piece of equipment, such as a wheelchair for a member who is wheelchair bound, is approved by the UM Department, the approval will be sent to the Case Management department.

3. The Case Management department will order and track approved requests for specialized DME.

B. Wheelchair Authorizations:

1. A contracted seating clinic vendor will be utilized. The seating clinic vendor will be given the name of a DME provider contracted with the health plan or IPA.

2. Orders will be entered into a Case Management database. The Case Management Department will maintain contact with vendors and members to assure that all DME is delivered in a timely manner, that instructions for use are fully explained to the member and/or caregiver and that the equipment delivered is in good working condition.

3. It will be the CM Department's responsibility to track pre-assessment interviews and assessments.

   a. The database will be queried weekly to track dates services are provided to these members.
   b. Case Managers will contact the seating clinic to assure that:

      (1) The member is contacted within 7 days of receipt of a referral from IPA.
      (2) An assessment is performed within 10 days of receipt of a referral from IPA
      (3) All assessments are performed by a licensed physical therapist.

4. The Case Management Department will perform follow-up phone calls to the DME provider and the member to assure that the DME/wheelchair ordered is delivered within 12 weeks. If equipment delivery occurs later than 12 weeks from the time of the assessment, the Case Management Department will notify the member of the delay.

C. Oversight:

1. On a weekly basis, the CM Department will notify the UM Department of all referrals that are closed because of delivery of equipment or change of member's needs or status.

2. On a monthly basis a report of all referral activity, including any open or pending referrals, is run to ensure compliance of timeliness of the referral process.

3. On a monthly basis all unused referrals will be run and sent to the UM Department for submission to PCPs to follow up with the members.

4. The Quality Management department will review all potential Quality of Care issues to determine whether a problem exists with any contracted vendor. All identified problems will be reported to the Quality Management Committee for review and resolution.

5. In addition, member satisfaction surveys will be monitored for concerns regarding DME.

FORMS:

Referral Authorization Worksheet

REFERENCES:
Policy and Procedure: Member Services Grievances
Policy and Procedure: UM4 Referral Authorization Process

SUBJECT: Cultural & Linguistics Service Standards & Monitoring **Policy:** QM.14
DEPARTMENT: Quality Management

Effective Date: February 2005
Last Revision Date: December 8th, 2023
Last Review: January 2026

SCOPE:

This applies to all lines of business.

PURPOSE

To ensure effective communication regarding treatment, diagnosis, medical history, and health education by providing cultural, linguistic, and sensory appropriate services for all Members, taking into consideration Members' beliefs, traditions, customs, and individual differences.

POLICY:
IPA shall provide culturally and linguistically appropriate services to Members. Specifically, they shall:

1. Recruit bilingual employees for appropriate positions whenever possible and enhance employees' bilingual skills and cultural sensitivity through employee development programs, as needed.

2. Provide twenty-four (24) hour access to interpreter services, including sign language interpreter services, at Key Points of Contact for all Members.

3. Provide translations of informational materials in Threshold Languages and meet the needs of Members with sensory impairments; and ensure materials will be at a 6th grade or less reading level

4. Refer a member to culturally and linguistically appropriate community services, as needed.

5. Maintain evidence of bilingual capabilities of the provider and staff.

6. The IPA will adjust the network, if necessary, based on the cultural & linguistic needs of its members.

7. The IPA will send a C&L referral activity report to the Health Plan according to the report timeliness requirement of the Health Plan.

To facilitate the development of programs and services, IPA shall collaborate with health plan partners to identify health education and cultural and linguistic needs by conducting a Group Needs Assessment (GNA) every three (5) years. In addition, the IPA will perform an annual assessment of Provider Office language capabilities. This may be done through a Provider Survey, on-site visits and during the credentialing process.

IPA shall develop C&L policies and procedures and shall designate a professional to be responsible for activities conducted under the policies and procedures.

IPA shall collaborate with the health plans to assess the bilingual proficiency of a provider that lists bilingual capabilities and shall submit results of such assessment as specified by health plans.

IPA shall monitor complaints and grievances and report complaints and grievances related to C&L services to the health plans.

DEFINITIONS:

California Relay Service: A telecommunications relay service, which provides full telephone accessibility to people who are deaf, hard of hearing or speech disabled available 24 hours a day, 365 days a year with no restrictions on length or number of calls placed. There is no charge for using the service within your local call area. Specially trained Communications Assistants complete all calls and stay on-line to relay messages electronically over a text telephone (TT), so called TTY for "Teletype" or verbally to hearing parties.

Concentration Language: More than 1000 members with the specified language.

Cultural and Linguistic (C&L) Services: Services to Members that include the hiring of bilingual and culturally sensitive personnel; providing interpreter services both in person and over the telephone, including signage; providing Members with translated materials; and referring Members to culturally and linguistically appropriate services.

Cultural Competency: The ability of health professionals to actively apply knowledge of cultural behavior and linguistic issues when interacting with Members from diverse cultural and linguistic backgrounds. The essential elements of cultural competency are:

1. An unbiased attitude that values and respects cultural diversity; a respect for the multifaceted nature and individuality of people.

2. Awareness that culture and cultural beliefs may influence health and health care delivery.

3. Recognition of the diversity among Members.

4. Skills to communicate effectively with diverse populations and applications of those skills in cross-cultural interactions to ensure equal access to quality health care.

5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socio-economic status, physical or mental ability, gender, sexual orientation, age, or disability.

Emergency Medical Condition: 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 hea1th and medicine could reasonably expect the absence of immediate medical attention to result in:

1. P1acing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Group Needs Assessment (GNA): An evaluation performed to identify the health education, linguistic and cultural needs of IPA Members, including those groups whose primary language are non-English, for the purpose of deve1oping programs and services.

Key Points of Contact: Service sites that provide Members with access to health care services, both medical (urgent care or face-to-face encounters with providers) and non-medical (Member services, appointments, or orientation meetings).

Limited English Proficient (LEP): Members who cannot speak, read or write or understand the English language at a level that permits them to interact effectively with health care providers.

Threshold Languages: Languages spoken by the Limited English Proficient (LEP). The Threshold Languages are determined by the health plans in accordance regulatory agencies.

Urgent Care: Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throat, minor lacerations, and some broken bones.

PROCEDURE:

A. Group Needs Assessment (GNA)

1. IPA shall assign a professional to collaborate in conducting the GNA. This staff shall be responsible for coordinating with health plan staff to implement effective health education programs and cultural and linguistic programs resulting from the GNA and for reporting on the GNA and related activities, including annual survey of provider office bilingual capabilities to the IPA Quality Improvement Committee as required.

2. IPA shall provide input to the health plans in development of a C&L services plan and assist in the identification of resources needed for the implementation of health education initiatives.

3. The IPA will perform and annual assessment of provider office language capabilities. This may be done as part of the annual provider survey, a separate language capability survey, on-site visits and during the credentialing process.

B. Employee Recruitment and Development

1. IPA shall make its best efforts to recruit qualified culturally sensitive and bilingual employees, especially for positions that require direct Member communication.

2. IPA shall assess the language capability of an employee to determine the employee's proficiency level for an assignment that includes the use of bilingual skills.

3. IPA shall enhance an employee's ability to communicate managed care and medical care terminology to a Member in such Member's native language through training and development programs.

4. IPA shall provide comprehensive staff training to ensure a Member with a sensory impairment is assisted in accessing information, services, and benefits.

5. IPA shall encourage employees to attend cultural sensitivity seminars and workshops offered by health plans, professional organizations, universities, or colleges to develop Cultural Competency including but not limited to:

   a. Developing attitudes that value and respect diversity.

   b. Enhancing knowledge and awareness of beliefs, behaviors, and preventive health practices.

   c. Acquiring skills to communicate with Members with diverse language needs, including sign language interpreter services; and

   d. Developing the ability to address the health needs of diverse populations.

C. Interpreter Services and Access for Members with Sensory Impairments

1. IPA shall provide Members with FREE linguistic interpreter services, sign language interpreter services, and information about the California Relay Service (CRS) to Members with hearing impairments and auxiliary aids for Members with visual impairments, as necessary to ensure effective communication regarding treatment, diagnosis, medical history, or health education. (See P&P QM.15: Interpreter Services)

2. The IPA will make a good faith effort to supply materials in alternate format, ie. Audio, Braille, Large Print, etc.

D. Translation Services

1. IPA shall provide informational materials translated in Threshold Languages including, but not limited to the Welcome packet, newsletters, outreach flyers and brochures, consent forms, grievance forms, selection form instructions, and health education materials. In addition, for those documents not available in other languages that may be required, IPA shall arrange for oral translation.

2. To ensure the quality of the translation, IPA shall select qualified translators to translate the documents and submit the document for final approval from the health plan prior to distribution to members.

    - Health Education materials and NOA letters will be the health plans pre-approved materials and letters.

3. When translation service is requested to a Health Plan, all requests will be logged and monitored by the C&L Coordinator. The log will include:

    - Date and time the request for translation or vital document was received.
    - Date and time the member request and/or vital document was forwarded to the Health Plan.
    - Any attachments that are provided with the letter to the member including but not limited to clinical guidelines or medical policy.

4. Requests related to urgent healthcare services will be forwarded within one business day of receipt of request. Requests related to non-urgent healthcare services will be forwarded within two business days of receipt of request.

E. Referral to Culturally and Linguistically Appropriate Services.

1. IPA shall maintain a listing of community-based and faith-based organizations and shall refer members for psychosocial and other culturally and linguistically appropriate community services, as needed.

2. PCPs or Members may self-refer to community based, and faith-based organizations as needed.

3. If a PCP needs assistance in locating a special service or program, the PCP may contact the MSO C&L Coordinator or submit via a standard referral request. The C&L Coordinator will locate the program, document the request, and communicate back to the PCP.

4. Referrals to community based and faith-based organizations are logged as received.

5. As part of care planning, a nurse Case Manager may recommend community-based programs to members. The CM nurse will document referral and whether the member actively participates in the recommended program.

F. Monitoring and Evaluation of Cultural and Linguistic Services

1. The IPA will ensure members are provided with culturally and linguistically appropriate services by monitoring and evaluating the following:

    a) All members who have formally requested face-to-face interpreting assistance provided by an Interpreting Service will be included in the annual Member Satisfaction Survey to assess their knowledge and satisfaction with Interpreting Services.

    b) An annual survey will be completed to identify the providers Health Education Material needs and languages needed.

c) An annual survey will be conducted of the language spoken in the PCP office by the Physician and Staff, including a self-assessment of their proficiency in the language spoken. The IPA will maintain an updated log of languages spoken in the Provider's offices, listing by Physician and Staff.

d) The IPA will collaborate with the health plans to assess the proficiency of the Providers and Key Point of Contact who are bilingual. The IPA shall submit the results of such assessments to health plans as required by the health plans.

e) The Provider Facility Site Review, [performed by the Health Plan], assess the provider's compliance with documentation and evidence of Health Education materials in required topics, referrals to community-based programs, and documentation in member's file, and posting of FREE interpreting services sign. Any identified areas of non-Compliance with corrective action reported by the Health Plan will be reported to the QI Committee, assistance with corrective action may be requested and review of final compliance will be assessed.

f) The providers will receive updated community resource lists.

g) IPA shall provide initial and continuing training to contracted providers on Cultural Competency issues. IPA may conduct training in conjunction or collaboration with health plan or work with community organizations or educational institutions to provide the training.

FORMS:

Request/Refusal Form for Interpretive Services

REFERENCES:

Policy and Procedure:

MS.1 Member Grievances
PR.1 Provider Grievances

Title 45, code of Federal Regulations, Section 84.52

A Public Agency

CalOptima

Better. Together.

Cultural Competency

2022

Learning Objectives

- After completing the course you will understand:
  - The variety of cultural groups in CalOptima's service area
  - Services that promote equal access to health care services and are responsive to a member's cultural and linguistic needs.
  - The meaning of cultural competent care.

Course Content

- Terms and Definitions
- Orange County Culture and Demographics
- Regional Cultural & Linguistic Needs
- Elements & Components of Culture
- HIV Disease Stigma
- Cultural Competence
- Pillars of Cultural Competency
- Solutions To Reduce Racial & Ethnic Disparities
- Available Resources

Note: Content of this course was current at the time it was published. As Medi-Cal and Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

Cultural Competency

Objectives:

- Identify members with potential cultural or language needs where alternate communication methods are needed.
- Use informational materials that are culturally sensitive.
- Determine that appropriate processes and tools are available to support communication and remove barriers.
- Ensure persons interacting with CalOptima members have an understanding of how culture and language may influence health.

Terminology

Definitions:

- **Race:** any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape.
- **Ethnicity:** a group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- **Culture:** the ideas, customs, skills, arts, etc. of a people or group, that are transferred, communicated, or passed along, as in or to succeeding generations.

Webster's New World College Dictionary, Fifth Edition

Total U.S. Population = 332.8 Million

Totals and Percentages of U.S. Population by Ethnic Group		
White (Non-Hispanic)	200.7 million	60.3%
Latino/Hispanic	61.5 million	18.5%
African American	38.2 million	11.5%
Asian American	23.6 million	7.1%
American Indian/ Alaska Native	5.6 million	1.7%
Native Hawaiian and other Pacific Islander	2.9 million	0.9%

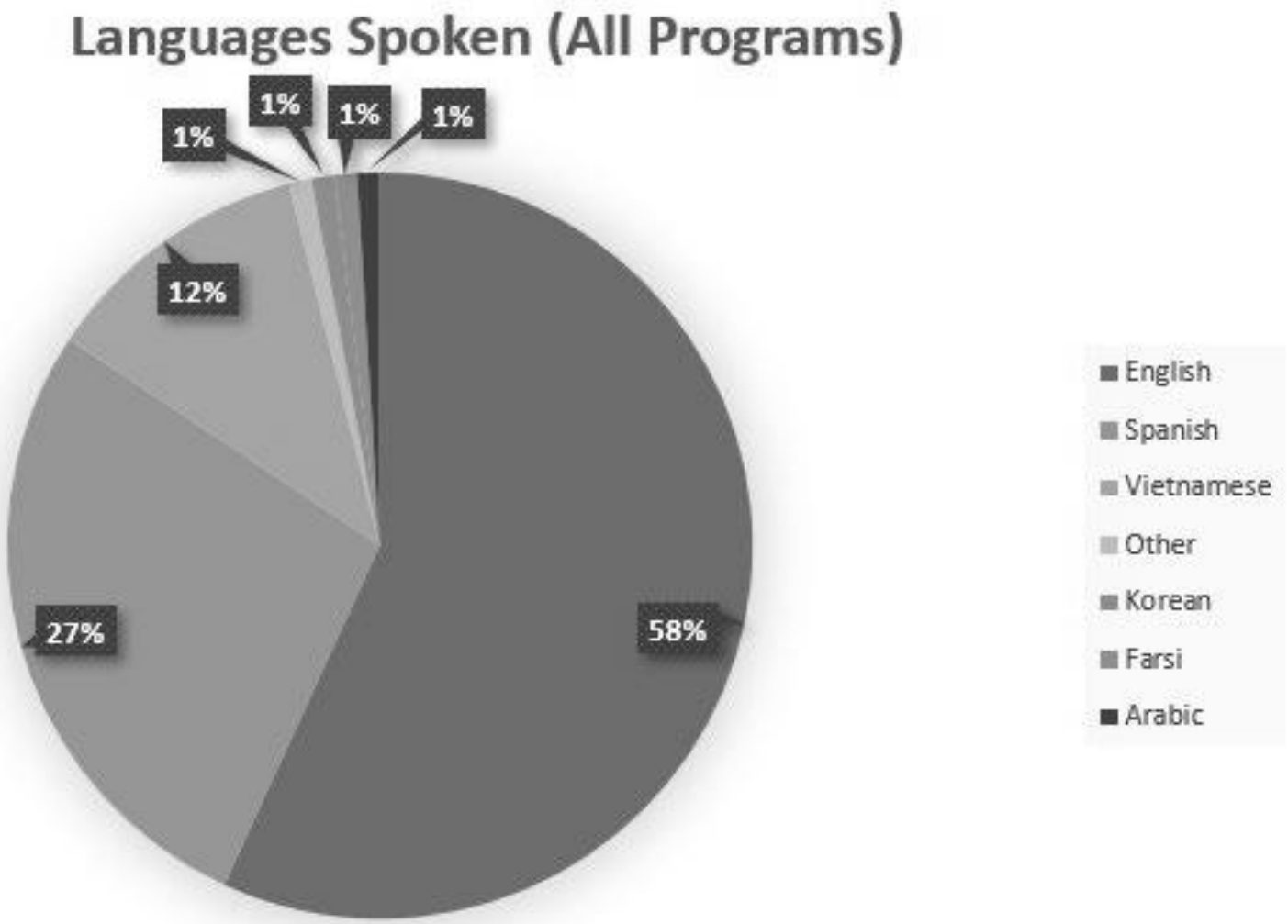
U.S. Census Bureau, 2020

Orange County Population = 3.1 Million

Totals and Percentages of Orange County Population by Ethnicity		
White (Non-Hispanic)	1.7 million	54.4%
Latino/Hispanic	803.1 Thousand	25.2%
Asian American	379.2 Thousand	11.9%
African American	152.9 Thousand	4.8%
Native Hawaiian and other Pacific Islander	82.8 Thousand	2.6%
American Indian/ Alaska Native	35 Thousand	1.1%

U.S. Census Bureau, 2020

Languages of CalOptima Members



Based on CalOptima membership data as of September 2021

CalOptima
A Public Agency
Better. Together.

Regional Cultural & Linguistic Needs

Orange County has unique cultural needs in each of the four regions.

- North county serves a large Hispanic and Vietnamese population.
- Central county serves a primarily Hispanic population.
- West county serves a large Vietnamese community.
- South county has an emerging Middle Eastern community.
- CalOptima‘s threshold languages are English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.

CalOptima Cultural & Linguistics department, 2019

Other Populations

- Veterans
- Lesbian, gay, bisexual, transgender
- Homeless

Homeless

- The 2018 annual point-in-time report from the Department of Housing and Urban Development (HUD) estimated on a single night in January:
  - 552,830 people experienced homelessness in the United States.
  - 65% were staying in sheltered locations, while 35% were in unsheltered locations.
  - 67% of the people experiencing homelessness were adults in households without children.
  - 33% of those homeless were a part of a family.
  - 20% were children.
  - California accounted for:
    - 30% of all people experiencing homelessness as individuals.
    - 49% of all unsheltered individuals.
    - 54% of all unsheltered homeless unaccompanied youth

2018 Annual Homeless Assessment Report to Congress

Homeless (cont.)

The number of people living on the streets in Orange County is rising each year.

	Total Population	Homeless Population	Percentages
2013 Count	3,090,132	4,251	0.14%
2015 Count	3,145,515	4,452	0.14%
2017 Count	3,194,024	4,792	0.15%
2018 Count	3,185,968	6,860	0.22%
2019 Count	3,198,000	6,860	0.21%

Common contributors to homelessness include:

- Poverty
- Lack of affordable housing and employment opportunities
- Domestic violence
- Health and mental health issues, including the effects of trauma

Orange County CoC Homeless Count & Survey Report, 2020

Implications

- Changing U.S. ethnic and racial demographics
- Definition and manifestations of health and mental health disparities
- Disparities in mental health status, care delivery, and treatment response
- Measures of cultural competence used as a guide in efforts to decrease or eliminate health disparities

National Quality Forum, Endorsement Summary: Healthcare Disparities and Cultural Competency Measures, 2012

Knowledge Check

1. Race is:
   a) Common Language
   b) Shape of eyes
   c) Physical traits such as hair color and texture, eye color, skin color or body shape
   d) Place of birth

2. Ethnic is a group having:
   a) Common cultural heritage
   b) Common nationality
   c) Common language
   d) Common history
   e) All of the above

Knowledge Check (cont.)

3. Culture is:
   a) Ideas, customs, skills, arts, etc. of a people or group
   b) Civilization of a particular people or group
   c) Place of birth of a particular people or group
   d) All of the above

4. The third largest ethnic group in Orange County is:
   a) Latino/Hispanic
   b) Asian American
   c) African American
   d) Native Hawaiian and other Pacific Islander

Knowledge Check Answers

1. c) Physical traits such as hair color and texture, eye color, skin color or body shape
2. e) All of the above
3. a) Ideas, customs, skills, arts, etc. of a people or group
4. b) Asian American

Culture

An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; is dynamic in nature.

National Center for Cultural Competence, 2006

Elements and Components of Culture

- Collective values, experience, beliefs — beliefs about health and health care, as well as behavioral styles
- Non-verbal communication
- Perspectives, world views, frames of reference
- Community motivation and social identification
- Cultural awareness
- Languages and dialect

Factors Influencing Culture

- Age
- Gender
- Socioeconomic status
- Ethnicity
- National origin
- Religion
- Geographical location
- Migration
- Sexual orientation
- Gender identity

Cultural Divide

- High likelihood of ethnic and cultural differences between health care providers and their members
- Disproportionate number of health care system and health care professionals to serve the increasing number of CalOptima members with diverse ethnic and racial backgrounds
- Lack of understanding about the importance of cultural and ethnic factors in health care

Ethnic and Racial Health Disparities

- Difference and inequalities among racial, ethnic, linguistic and cultural groups effect:
  - Risk and predisposition to disease
  - Disease prevalence, health status and diagnosis
  - Differences in quality of health care delivery
  - Health outcomes and mortality

Higher Death Rates

- African-Americans
  - Heart disease, stroke, breast cancer, lung cancer, prostate cancer, diabetes, and kidney disease
- Asian-Americans and Pacific Islanders
  - Cancer, heart disease, stroke and diabetes
- Hispanics
  - Cancer, heart disease, stroke and diabetes
- American Indians and Alaskan Natives
  - Heart disease, diabetes and chronic liver disease

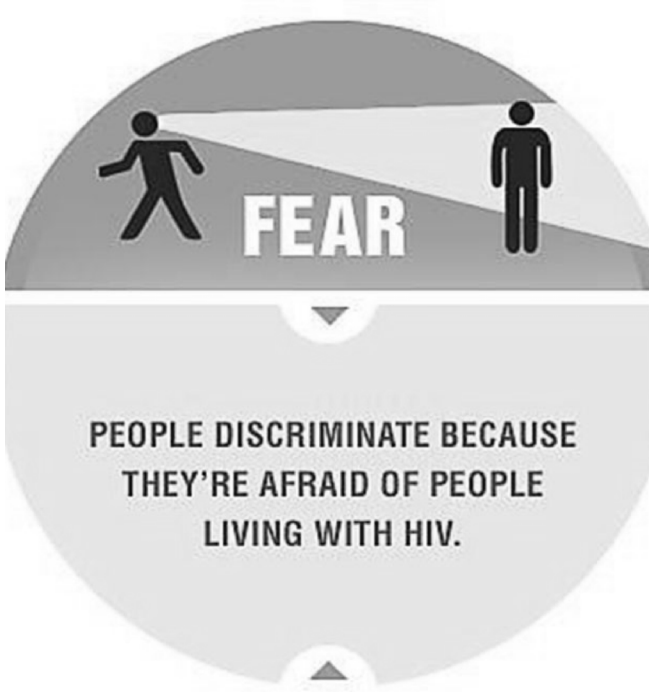
Centers for Disease Control and Prevention 2018

Disease Stigma

- Stigma
  - An association of disgrace or public disapproval with something, such as an action or condition.
- Disease Stigma
  - Negative attitudes and beliefs about people with a specific medical condition.
  - Prejudice that comes with labeling an individual as part of group that is believed to be socially unacceptable.
- Discrimination
  - The behaviors that result from negative attitudes or beliefs.
  - The act of treating people living with a specific medical condition differently than those without.

HIV Disease Stigma

- Stigma is intensified if someone has a disease or condition which is:
  - Life-threatening
  - Contagious
  - Associated with behavior
  - Associated with moral fault
  - Visible



Source: Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention, September 2020

Effects of HIV Stigma

- The emotional well-being and mental health of people living with HIV are often affected.
  - May fear they will be discriminated against or judged negatively if their HIV status is revealed.
  - Often internalize the stigma they experience and begin to develop a negative self-image.
  - May start to apply stereotypes about people living with HIV to themselves.
  - May have feelings of shame, fear of disclosure, isolation, and despair.
  - Feelings may keep them from getting tested and treated for HIV.

Caring for Members

- To help diminish the stigma:
  - Learn more about the disease.
  - Be mindful of how you talk about HIV and people living with HIV.
  - Talk openly about HIV to help normalize the subject.
  - Correct misconceptions and help others learn more about HIV.
  - Lead others with your supportive behaviors.
  - Provide reasonable accommodations, when appropriate or feasible and do not deny services to any individual because of a medical condition, including HIV/AIDS.

Cultural Competence

What is cultural competence?

- The state of being capable of functioning effectively in the context of cultural differences.
- A set of congruent skills, attitudes, polices and structures, which come together to enable a system or agency to work effectively in the context of cultural differences.
- Attention to the dynamics of difference.
- Continuing self-assessment regarding culture.
- Acceptance and respect for differences.
- Ongoing development of cultural knowledge and resources.
- Dynamic and flexible application of service models to meet the needs of minority populations.

Three Pillars of Cultural Competence

Language Access Services	Culturally Competent Care	Organizational Support

All are designed to:

- Develop attitudes that value and respect diversity
- Enhance knowledge and awareness of beliefs, behaviors, and preventive health practices
- Develop communication skills for members with diverse language needs, including sign language interpreter services
- Integrate Health Equity strategies to address the health needs of CalOptima's diverse population

Language Access

A CalOptima member with a language preference other than English may need:

- A health care provider, physician assistant, nurse practitioner, social worker who speaks the language
- A professional interpreter
- A family member
- Appropriate in-language signage communicating the different services that are available

Language Services

- CalOptima members have the right to certain language services:
  - 24-hour access to no-cost interpreter (including American Sign Language, Telecommunications Device for the Deaf [TDD] or California Relay Services) at key points of contact
    - Customer Service call center
    - Provider settings (network capable of meeting diverse cultural needs, including many pharmacies that offer services in several languages)
    - Health Risk Assessment (HRA) and Interdisciplinary Care Team (ICT) meetings
- Notice of interpreter services is required
  - Provided in Member Handbook
  - Posters and flyers at care sites and member orientation setting

Language Services (cont.)

- CalOptima has the responsibility to ensure effective communication.
  - Member information and health education materials translated in the following languages:
    - Spanish
    - Vietnamese
    - Korean
    - Farsi
    - Chinese
    - Arabic
  - Members may request materials in alternative formats: Braille, digital, audio or large print.

Translated Materials

Multi-lingual settings and materials translated in the threshold languages are made available to members.

- New member orientation group meetings
- Annual newsletter, with list of community resources
- CalOptima Member Handbook
- Explanations of Benefits (EOBs)
- Disclosure forms
- Provider listings or directories
- Marketing materials
- Form letters
- Preventive health reminders
- Member surveys

Written materials are translated at a sixth-grade reading level or appropriate level determined by field testing.

Ongoing Language Analysis

CalOptima monitors non-English speaking members ability to obtain health care services.

Language Study Analysis and Areas of Improvement

- Language data from CalOptima providers and members are used to determine provider adequacy by language for non-English speaking members.
- Language standards for each threshold language are determined.
- A plan of action for health network or medical group with member to provider ratio at 500:1 and above is developed.

Culturally Competent Care

- Due diligence on member's background
  - Race, religion, preferred language support network, major pre- and post-immigration trauma, etc.
  - Inquire about alternative / folk treatments
- Use a culturally appropriate course of inquiry
  - "Do you believe that it's your destiny to have this condition, or do you believe it's your destiny not to have this condition?"
  - "What have you done so far to treat your ailment (e.g., acupuncture, herbs, acupressure, etc.)?"

Culturally Competent Care (cont.)

- Be aware of body language (eg, verbal / nonverbal cues) while meeting with members.
  - Helps to reduce the members' bias / apprehension towards the doctor
- Embrace the significant role played by family members in the health of the individual.
- Do not discount culturally specific treatments if they do no harm.
- Provide simple questionnaires for members to fill in at the time of visiting the doctor.
  - Include questions describing physical symptoms vs actual ailments to elicit more open communications
  - Fosters dialogue and encourages members to ask more questions

8 Q's for Members

Explanatory Model (EM) of their illness

(by Arthur Kleinman):

1. What do you call your problem?
2. What has caused it?
3. Why do you think it started when it did?
4. What does it do to you?
5. How severe is it?
6. What do you fear most about it?
7. What are the chief problems it has caused you?
8. What kind of treatment do you think you should receive?

Organizational Support

CalOptima

Partner with community-based physician and/or specialist clinics to improve health and equity

Collaborate with community centers, community leaders, religious center within ethnic neighborhoods

Encourage offices to deploy specific strategies to address the multiple determinants of health in addition to language assistance

Organizational Support (cont.)

- CalOptima monitors and adheres to the Culturally and Linguistically Appropriate Services (CLAS).
  - Recommendations and standards disseminated by the Office of Minority Health of the U.S. Department of Health and Human Services (HHS)
- Encourage health care organizations to implement standards like CLAS.
- Aid health care providers and health care organizations to deliver culturally competent care.
  - Defined by the Office of Minority Health as the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by members to the health care encounter.

Potential Solutions to Reduce Racial and Ethnic Disparities

- Support capacity development
- Increase representation in research
- Promote outreach to and collaboration with communities
- Promote voluntary Unconscious Bias training across the health care delivery system, including provider Continuing Medical Education (CME)
- Establish cultural competence initiatives

Knowledge Check

1. CalOptima's threshold languages include:
   a) English, Spanish, Vietnamese, Farsi and Korean
   b) English, French and Spanish
   c) English, Spanish
   d) English, Spanish, Vietnamese, Farsi, Arabic, Korean and Chinese

2. CalOptima members have the right to certain language services.
   a) True
   b) False

Knowledge Check (cont.)

3. Factors influencing culture include:
   a) Age and gender
   b) Ethnicity and national origin
   c) Religion and sexual orientation
   d) All of the above, and more including socioeconomic status, geographical location, and migration

4. Ethnic and racial health disparities include:
   a) Risk and predisposition
   b) Disease prevalence, health status, and diagnosis
   c) Health care difference in quality and health outcomes and mortality
   d) All of the above

Knowledge Check

5. Cultural competence is:
   a) Being capable of functioning in the context of cultural differences
   b) Speaking the same language
   c) A set of congruent skills, attitudes, policies and structures that enable effectiveness
   d) All of the above
   e) a and c

6. The 3 main pillars of cultural competence are:
   a) Compassion, being bi-lingual and open to diversity
   b) Language access services, culturally competent care and organization support
   c) Language access services, cultural awareness and a diverse provider network

Knowledge Check Answers

1. d) English, Spanish, Vietnamese, Farsi, Arabic, Korean and Chinese
2. a) True
3. d) All of the above, and more including socioeconomic status, geographical location, and migration
4. d) All of the above
5. e) a and c
6. b) Language access services, culturally competent care and organization support

Available Resources

- Schedule a language interpreter or American Sign Language interpreter:
  - Contact the member's assigned health network, if the member is in a health network
  - Call CalOptima's CalOptima Customer Service department
    - 24 hours a day, 7 days a week.
    - Toll-Free: **855-705-8823**
    - TTY: **711** or **800-735-2929**
- To request printed member or health education materials in alternate formats, contact CalOptima's Customer Service.

Authorities

- 2018 Annual Homeless Assessment Report to Congress (HUD)
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services (CMS)
- Medicare Managed Care Manual, Chapter 4
- National Center for Cultural Competence
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- National Quality Forum, Endorsement Summary: Healthcare Disparities and Cultural Competency Measures
- Office of Minority Health, Nationals Standards on Culturally and Linguistically Appropriate Services (CLAS)
- Orange County CoC Homeless Count & Survey Report
- Title 42, Code of Federal Regulations, Section 422.112
- Title 45, Code of Federal Regulations, Section 84.52
- Title 9, Code of Federal Regulation, Section 1810.410 (f) (3)
- U.S. Census Bureau, 2019
- Webster's New World College Dictionary, Fifth Edition

References

- OneCare Physician Medical group (PMG) Service Agreement
- CalOptima Three-Way Contract with Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
- CalOptima Policy AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training
- CalOptima Policy CMC.1001:Glossary of Terms
- CalOptima Policy CMC.1003: OneCare Connect Staff Education and Training
- CalOptima Policy CMC.4002: Cultural and Linguistic Services
- CalOptima Policy CMC.9001: CalOptima Member Complaint Process
- CalOptima Policy EE.1103: Provider Education and Training
- CalOptima Policy GG.1517:Transgender Services
- CalOptima Model of Care


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

SUBJECT: Interpreter & Translation Services **Policy #:** QM15
DEPARTMENT: Quality Management - Cultural Linguistics

Effective date: October 10, 2001
Last Revision date: March 31, 2022
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure all limited English proficient and Hearing-Impaired members are provided FREE language assistance. To provide a mechanism to ensure efficient communication and access for its members who have specific language needs at Key Points of Contact, 24 hours a day, 7 days a week so members can make informed health decisions. Types of Interpreting Services available are face-to-face, telephonic and/or California Relay Service for Hearing Impaired.

POLICY:

Both translation and interpretation enable communication across languages from source to target. Translation deciphers the meaning of the written word from one language to another. Interpretation conveys the meaning of the spoken word from one language to another.

Providers are required to maintain evidence of bilingual capabilities of providers/staff.

Each PCP office is required to post a sign that FREE Interpreting Services are available upon request; and are provided in all threshold languages. (See attached sign distributed from LA Care).

Interpretive services may be used in medical and non-medical points of contact.

If a Provider's office cannot identify a member's language, they may use "point to" cards or may contact the Member Services Department (714) 947-8600 for assistance.

Providers are given a grid showing process for Interpreting Services according to the health plan the member is assigned, including the contact number for HealthSmart Member Services Department.

IPA shall utilize a vendor for telephone interpretation services for languages not covered by employees or for Urgent Care and Emergency Services; however, face-to-face interpretation is preferred.

The provider will utilize the "Interpreting Services Grid" for reference of Interpreting Services available by plan. This grid is updated at a minimum annually and disseminated to all P&Ps.

Face-to-face interpreter services, including sign language interpreter services, may be scheduled through a contracted vendor or an interpreter who is on "on-call" status.

Interpreting services will be offered FREE to all members with any specific language needs.

Members will not be charged any fee for interpreting services.

All reasonable efforts will be made to provide an interpreter in time to adequately assist with all necessary care, including Urgent Care and care for an Emergency Medical Condition.

Members have the right to file a complaint if they fail to receive requested interpreting services or are unsatisfied with the interpreting services provided.

If a provider office identifies a member as being limited English proficient and the member is already at the office, telephonic interpretation should be used immediately to avoid any delay in service.

Providers shall utilize Telecommunications Device for the Deaf (TDD), the California Relay Service (CRS), or a comparable device or service available to assist a Member with a hearing impairment.

For a member with a visual impairment, the Providers will utilize informational or educational materials available in the Threshold Languages.

The IPA will make a good faith effort to supply materials in alternate format upon request. Alternate formats include but are not limited to Audio, Braille, Large Print [no less than 20 Arial Font for visually impaired], accessible format, such as data CD, as well as requests for other auxiliary aids and services that may be appropriate. Special request needs will be documented for future needs and reported as required by Health Plans.

If a member selects an electronic format, such as an audio or data CD, the information may be provided unencrypted but only with the member's informed consent. The member will be contacted regarding alternate format, that unless the member requests a password protected format, the member will be receiving notices and information in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Members may request notices and information in a password protected electronic format and must provide separate unencrypted instructions on how the member is to access the encrypted information.

Members who state they have difficulty reading print communications on account of a disability must be notified of their right to receive auxiliary aids and services, including alternate formats.

Auxiliary aids and services must be provided to a family member, friend, or associate of a member if required by the ADA, when said member is identified as the member's authorized representative or is someone whom it is appropriate to communicate with (i.e., a disabled spouse of a member).

Alternative format needs shall not be reduced or terminated without adequate notice in required timeframes explaining reason for action and including appeal information.

If the provider identifies a member with this need and does not have the materials needed on site, he may contact the Health Education Coordinator (need telephone #) to obtain required information.

The Providers office will document member's request or refusal of interpreting services, including language spoken.

The Providers office will not require a family member or friend to act as interpreter for a member to be seen.

The Provider will follow the interpreting service grid by the member's corresponding health plan to determine the process for obtaining interpreting services.

The Provider shall not require a Member to use friends or family as interpreters. A Member's friends or family may be used as interpreters if the following conditions are met:

a. It is requested by the Member.

b. It will not compromise the effectiveness of service;

c. It will not violate the Member's confidentiality; and

d. The Member is advised that an interpreter is available at no cost.

After offering Interpreting Services, if the member would prefer to use a family member or friend, the provider must document in the medical chart the member's refusal of outside service and document name and relationship of interpreter being used.

Providers are prohibited from using minors to interpret.

HealthSmart's Member Services Department may also receive phone calls from LEP members.

A list will be kept of all languages spoken within HealthSmart and the qualifications of each employee within the language spoken. HealthSmart will ensure a self-assessment survey is completed for all bilingual employees and kept on file, until such a time the health plan provides a formal mechanism for assessment.

If HealthSmart receives a phone call and does not have an employee proficient in the member's identified language, HealthSmart will contact the member's corresponding Health Plan to be connected to the AT&T Language Line.

When telephonic Interpreting Services are required, the providers will contact HealthSmart's C&L Coordinator who will assess eligibility and begin the process according to the member's health plan.

The member's corresponding health plan will connect with their AT&T Language Line to assist in communicating with the member.

A roster of all contracted providers, the languages spoken by the physician and the language spoken by the staff will be made available to all Primary Care Providers, the Medical Directors, and HealthSmart Staff. This list will be updated annually. The list will be used to assist in direction to specialty providers for members with language specific needs, however the member still has the right to request an interpreter.

A list of all languages spoken by HealthSmart employees will be updated annually and maintained.

The Referral Authorization Worksheet will contain an area to identify the member's primary language.

All attempts will be made to ensure that the primary language of the member is spoken within that referral service or specialty office. However, the provider and members can still request an interpreter to attend.

When requesting a face-to-face interpreter to assist in consultation with a specialty provider or service, the provider will circle Interpreting Assistance and enter the member's language need.

Setting up an interpreter will not delay the approval of service; however, time should be allowed to set up a face-to-face interpreter.

In cases where the member and/or provider requests an interpreter to attend an appointment with the member (face-to-face), the provider will contact the C&L Coordinator in advance for this service.

In some cases where coordination is to occur through the health plan, 5-7 days notice may be required.

When possible, a Provider shall ensure the assignment of the same interpreter to a Member who requires follow-up care.

In cases where the health plan is responsible for providing this service, the health plan may require a request form to be submitted prior to setting up the service.

In the case where HealthSmart uses its contracted provider, notice is also required to set up the face-to-face interpreter.

If services are needed urgently, then a telephonic interpreter will be utilized.

The C&L Coordinator will keep a log of Interpreting services coordinated and follow up to confirm. The C&L Coordinator will also log into the system the member's need, service provided and by whom for any future needs.

The providers and staff will be notified of Cultural Competency Training programs and encourage provider offices to attend.
Materials interpreted by HealthSmart will have a signed attestation for each document that is translated by a qualified vendor or staff.

The IPA will maintain a list of all translated documents that are obtained from the health plan.

DEFINITIONS:

Cultural and Linguistic Services – Services to members that include the hiring of bilingual and culturally sensitive personnel; providing interpreter assistance both in person and over the telephone, including sign language interpreter services; providing members with translated and/or other materials to meet the needs of sensory impaired members; and referring members to culturally and linguistically appropriate services.

Limited English Proficient – (LEP): members who cannot speak, read, or write or understand the English language at a level that permits them to interact effectively with health care providers.

Threshold Language – Language spoken by Limited English Proficient members. The threshold languages are determined in accordance with the Department of Health Services guidelines.

California Relay Service – A telecommunications relay service, which provides full telephone accessibility to people who are deaf, hard of hearing or speech disabled available 24 hours a day, 365 days a year with no restrictions on length or number of calls placed. There is no charge for using the service within your local call area. Specially trained Communications Assistants complete all calls and stay on-line to relay messages electronically over a text telephone (TT), so called TTY for "Teletype" or verbally to hearing parties.

PROCEDURE:

A. All Providers will be sent a sign to place in their office informing members of the availability of Interpreting Services. The sign will be posted in plain view for all members to see. Signs may be copied and put in each exam room if the provider chooses.

B. If a member refuses an Interpreting Service and prefers a friend or family member to interpret for them, the Provider and/or will ensure that this is documented in the member's file, including language requested.

C. At each visit the member will be offered interpreting service, even if they have refused in the past. The provider will continue to document any member refusal for interpreter service at each occurrence of refusal of service.

D. If the HealthSmart Member Services Department requires assistance to or from a member with specific language need or is requested to assist in obtaining language line services during business hours, they will follow the following procedure:

1. Place the call on Conference hold using the "Phone conference" feature. Place the non-English speaker on hold by pressing the "Conf" button.

2. Call the corresponding health plan's Member Services Department (See attached List) or AT&T Line.

3. Provide the following information:
    a. Organization name
    b. Client Name and ID Number
    c. Personal Staff Codes
    d. Specific Language required

4. Wait for the Language Line Operator to conference the Interpreter.

5. Brief the interpreter on the nature of the call and what you want to accomplish.

6. Add the non-English speaker to the line by pressing the Conference feature to connect the caller.

7. Confirm that the Interpreter and the Member or Provider can hear one another.

8. Say "End of Call" to the Interpreter when the call is completed.

9. Document the call.

E. If the request for a face-to-face interpreter is made by telephone and/or as part of a referral service, the provider will need to contact the C&L Coordinator and provide the following to set up:
1. Provider Name and telephone number & Contact person
2. Language need of member (including American Sign Language)
3. Patient Information (Name, gender, DOB, assigned health plan, etc.)
4. Date and time of appointment and estimated duration needed.
5. Location and type of Appointment
6. Any Special instructions or considerations.

F. If the request came along with a Referral Authorization Request, the referral authorization will be obtained first, then all paperwork forwarded to the C&L Coordinator. The C&L Coordinator will coordinate with all parties to set up the service, will log, then follow up with all parties to ensure that the Interpreting Services occurred, and satisfaction noted.

G. If a Provider needs to contact a member who is hearing impaired, the Provider will contact the California Relay Service by calling 1-888-577-5379. A Communications Assistant will request the area code and telephone number of the person you wish to contact. The provider is encouraged to speak as if he is talking directly to the patient, saying "Go Ahead" after completing each sentence. (Avoid saying, "tell him "Or "tell her"). The Communications Assistant will type everything you say to the member. This includes any side conversations, background noise, etc.

H. If at any time a Provider, HealthSmart staff member cannot identify a member's language, a phone call will be placed to the member's corresponding Health Plan to connect with a Language Line to assist.

I. If after hours Interpreting Services are required for a telephone call that was placed to HealthSmart, the Answering Service will connect to the AT&T Language Line by following #D-4 above. If necessary, the service may contact the on-call coordinator for HealthSmart. All providers will have a plan in place for after hour's calls, which will also address Language Line needs.

J. The C&L Coordinator will keep a log of C&L related activity in the C&L Binder. All C&L related activities will be noted in the member's eligibility file to ensure that services are consistently set up to meet member's specific language need.

K. Any materials requiring translation will be forwarded to the regulatory agencies for review prior to distribution.

FORMS:

Referral Authorization Worksheet
LA Care FREE Interpreting Assistance notice.
UHP Healthcare FREE Interpreting Assistance notice.

REFERENCES:

Title 28, Code of Federal Regulations, Section 35.160
Title 45, Code of Federal Regulations, Section 84.52

SUBJECT: Health Education Activities **Policy #:** HE 1
DEPARTMENT: Quality Management

Effective Date: April 1, 1999
Last Revision Date: December 6th, 2023
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To improve and maintain health and wellness of members through Health Education, health promotion and intervention in a cultural and linguistically sensitive manner.

To ensure education through the use of Staying Healthy Assessments for Medi-Cal members.

To identify elements of health education programs including but not limited to, program promotion to members, member needs assessments and quarterly reporting of utilization and materials distribution.

POLICY:

The overall goals of health education are to:

- Promote appropriate health services.
- Encourage patient involvement with their personal health.
- Increase member knowledge of preventive health care services.
- Encourage risk reduction and behavior modification.
- Increase early detection of disease according to age and gender specific needs.
- Increase member's knowledge in coping with chronic conditions.
- Ensure educational services meet members' cultural and linguistic needs.
- Ensure Breastfeeding promotion.
- Ensure initial and annual evaluation and intervention for tobacco use.

Educating members may occur in any of the following ways:

- One-on-One educational training/Doctor and member
- Brochures on various topics relating to member needs.
- Topic specific classes relating to member needs.
- Video education materials

Specific Programs which may be offered through the health plan or through community-based services include Prenatal Classes, Weight Control, Diabetic Management, Asthma management, Smoking Cessation, Adult/Infant & Child Safety, Stress Management, Controlling Back pain, Arthritis and Osteoporosis, etc.

Brochures and/or information on the following topics are available to the members:

- Age specific anticipatory guidance, immunizations
- Asthma
- Breastfeeding Promotion
- Complementary and Alternative Medicine
- Dental
- Diabetes
- Domestic Violence
- Exercise
- Family Planning
- HIV/AIDS, Sexually Transmitted Diseases
- Hypertension
- Injury Prevention
- Lead Poisoning
- Nutrition
- Obesity/Weight Management
- Parenting
- Perinatal
- Prostate Specific Antigen
- Unplanned Pregnancy
- Self-Breast Exam
- Substance Abuse, Tobacco Education & Prevention

All written material distributed to members must be approved by the health plans and be at appropriate reading levels (6^{th} grade reading level or less). A language disclaimer / language assistance document will be attached to all materials distributed to members for information on how to obtain interpreting services to better understand the document, if needed.

A Heath Education Coordinator will be designated as the provider's contact to coordinate health education activities. The Health Education Coordinator will be responsible to:

- Maintain log of threshold languages of the IPA and make every attempt to ensure information and classes are available in these languages.

- Orient the providers to the various health plan and community resources that offer services.

- Provide assistance to the providers in directing patients into health education programs.

- Communicate with the health plans on an ongoing, as needed, basis.

- Provide assistance to the health plans in identifying and surveying members for specific programs or services.

The provider will refer the member to classes using a Referral Authorization Form.

The Health Education Coordinator will make every attempt to locate classes and materials that are culturally and linguistically appropriate to meet the member's needs and ensure no cost to Medi-Cal members.

Written health education materials are designed to assist members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes by including information on health conditions, management of health conditions, and self-care. Topics may include messages about preventive care, health promotion, screenings, disease management, and healthy living.

Health Education referrals will be logged separately from the Utilization referrals and will be forwarded to the Case Management Department for follow-up activities.

Effective as of November 30, 2016, APL (All Plan Letter) 16-014 supersedes MMCD Policy Letter 14-006. Providers are required to implement tobacco cessation interventions and a tobacco user identification system into their practices. The medical group will utilize the USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update" for provider training on tobacco cessation treatments. Providers will:

- Conduct initial and annual assessment of each patient's tobacco use and note this information in patient's medical record at each visit offered opportunity to stop smoking.

- Offer FDA-approved tobacco cessation medications (for non-pregnant adults). The provider will adhere to the prior authorization requirements as required in the members' health coverage.

- Refer patients to available individual, group and telephone counseling services and ensure that individual, group, and telephone counseling is offered at no cost to beneficiaries who wish to quit smoking, whether or not those beneficiaries opt to use tobacco cessation medications. For members refusing counseling services, members may be offered the California Smokers Helpline 1-800-NO-BUTTS. Referrals will be continuously offered until final success.

- PCP must:

    1. Review the SHA's questions on tobacco with the members and offer at least one face-to-face tobacco cessation counseling session per quit attempt.
    2. Ensure that individual, group, and telephone counseling is offered at no cost to members who wish to quit smoking, whether or not those members opt to use tobacco cessation medications, regardless of delegation of Health Education.
    3. Ensure that a minimum of at least four counseling sessions of at least 10 minutes in duration are covered for at least two separate quit attempts per year without prior authorization. Medical groups must offer individual, group, and telephone counseling without cost to the members, and no mandatory breaks between quit attempts.
    4. Ensure referrals to the California Smokers' Helpline (1-800-NO-BUTTS), a free statewide quit smoking service or other comparable quit line services. Providers are encouraged to use the Helpline's web referral, or Helpline's e-referral system if available in their area.
    5. Encourage use of the "5 A's" model (Ask, Advise, Assess, Assist, and Arrange), the "5 R's" (Relevance, Risks, Rewards, Roadblocks, Repetition), or other validated behavior change model when counseling patients.
    6. Ask all pregnant women if they use tobacco or are exposed to tobacco smoke and offer at least one face-to-face tobacco cessation counseling session per quit attempt. Counseling services must be covered 60 days after delivery, plus any additional days needed to end the respective month.
    7. Provide interventions to prevent the use of tobacco in children and adolescents.

Some recommendations to identify tobacco users are:

- Add tobacco use as a vital sign in the chart or Electronic Health Records
- Evaluation of annual Health Risk Assessments
- Use International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use.
- Place a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco.
- Record tobacco use in the SHA or other IHEBA.
- Record status on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM160)

PROCEDURE:

A. The provider will assess the member's health education needs and request the appropriate health education materials or initiate a referral to a topic specific class. This is also accomplished through the Staying Healthy Assessment for Medi-Cal members.

B. The Health Education Coordinator will disseminate educational material, programs, and class schedule information to providers. When correspondence is sent as general mailing, the information will be mailed according to the "Correspondence/Dissemination of Information" policy. When there is a member specific or urgent need for information, it may be disseminated by telephone or fax.

C. The provider is responsible for documenting all health education activities in the member's medical record.

D. The provider may refer to topic specific classes via the Referral Authorization Worksheet.

E. The referral will be faxed to the Health Education Coordinator, who will assist in direction to available classes as requested by the provider.

F. All measures will be taken to ensure that all brochures and classes meet the member's cultural and linguistic needs. Any materials requiring translation will be reviewed by the regulatory agencies prior to distribution.

G. A letter will be sent to the members with directions on how to attend the specific class.

H. A letter informing the class/program coordinator will be sent informing them of member referral for class activities.

I. The Health Education Coordinator will follow-up with the member and/or provider to ensure that the member participated in the class.

J. The class program coordinator is responsible for sending a reply to the provider and/or Health Education Coordinator informing of the member's attendance, evaluation of member's participation in the program activities, outcome, and current status.

K. All Health Education referrals will be logged and reported to the health plans monthly. In addition, a quarterly summary will be prepared for those health plans requiring Health Education activity quarterly.

L. A yearly evaluation of the Health Education Activities will be reported as part of the HICE year-end reporting and will be reviewed by the Quality Management Committee.

FORMS:

Referral Authorization Worksheet

SUBJECT: Individual Health Education Behavioral Assessment Tool (IHEBA) – Staying Healthy Assessment [SHA] **Policy#:** HE.2

DEPARTMENT: Health Education

Effective Date: January 2005
Last Revised: March 21, 2016
Last Review: January 2026

SCOPE:

This policy applies to all Medi-Cal Programs.

PURPOSE:

To define a process to ensure that an Individual Health Education Behavioral Assessment (IHEBA) is administered to all new and existing members.

To prioritize individual health education needs related to lifestyle, behavior, environment, and cultural linguistic background.

To assist providers to initiate and document focused health education interventions.

POLICY:

The Individual Health Education Behavioral Assessment Tool also known as "Staying Healthy Assessment" Tool will be administered to all new members within 120 days of the effective date of enrollment, as part of the initial health assessment, and to all existing members who present for a non-acute care visit or a scheduled health screening exam.

The IHEBA will be re-administered at appropriate intervals, as prescribed by the Department of Health Services (DHS).

The IHEBA will be offered and administered to a member in his/her primary language, where available.

The assessment tool will become a permanent part of the medical record and be referred to throughout the course of each patient's care.

Providers will utilize this tool to quickly review patient responses to identify behavior risks and prioritize risk categories.

Follow-up assessment questions will be utilized to identify health education needs and facilitate focused health education counseling.

Individual Health Education Behavioral Assessment tools will be completed by parents/guardians for children and self-completed by adolescents and adults.
The primary care provider (PCP) will protect members' confidentiality, especially as it relates to family planning, sexuality issues and alcohol/drug use and information.

The PCP will inform members of their right to refuse to answer any assessment questions and their right to refuse to complete the assessment. This refusal will be documented on the IHEBA form and in the medical record.

The PCP will also sign the form in the appropriate section along with the date planned for the next review.

HealthSmart MSO (HSMSO) will ensure ongoing provider education and support regarding the administration of the IHEBA.

DEFINITIONS:

Enrollment Effective Date: The first day of the month following notification by the Medi-Cal Eligibility Data System tape that a member is eligible to receive services from the IPA/PHC and that the member is not on "hold" status.

Facility Site Review: Any onsite review of a facility and medical records utilizing the current, or augmented, department of Health Services (DHS) approved audit tool, performed at a contracted provider's place of business.

Initial Health Education Behavioral Assessment Tool: A format to be utilized by PCPs to address individual health education needs related to lifestyle, behavior, environment, and cultural-linguistic background. Tools exist for specific age groups and are available through the Department of Health Services.

Primary Care Physician (PCP): A physician who focuses his or her practice of medicine to general practice or who may be a board-certified internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to members, initiating referrals, and maintaining the continuity of member care.

PROCEDURE:

A. An Individual Health Education Behavioral Assessment is offered to all new members as part of the initial health assessment and to all existing members who present for a non-acute care visit or a scheduled health screening exam.

   If a member declines to complete the Assessment, the refusal must be documented in the member's medical record.

B. The PCP will:

   1. Review the Assessment tool with the member during an office visit.

   2. Review the Assessment tool and risk reduction plan at least once a year with members who are present for a scheduled visit.

   3. Re-administer the Assessment tool at the appropriate age intervals for children and adolescents as specified on the "Staying Health" Assessment tools.

4. Administer the IHEBA tool annually for adolescents (12-17 years of age) and recommended annually but at a minimum every three (3) to five (5) years for adults (18 and older).

5. Assure documentation, at initial and subsequent visits, of health education interventions on the Assessment tool including intervention codes, date, and PCP signature. More extensive documentation in the progress notes is encouraged.

6. Include the Assessment tool, with the medical record history and problem list, as permanent part of the member's medical record.

    a. For members 18 years and older who answer "yes" to the alcohol screening question, an expanded screening questionnaire will be completed. The DHCS recommends using the Alcohol Use Disorder Identification Test (AUDIT) or Alcohol Use Disorder Identification Test – Consumption (AUDIT-C) forms. Members are allowed one expanded screening exam per year. Providers must maintain documentation of the initial assessment and expanded screening. See P&P UM42 SBIRT for more details on Alcohol Misuse Screening and Behavioral Counseling.

7. Provide assistance to members in completing the Assessment tool, if needed.

8. Include an English version of the IHEBA tool with any non-English tools completed by a member and maintained in the member's file.

9. Assure documentation in the medical record of all member noncompliance with the IHEBA process, including but not limited to member refusal to complete the form, and member refusal to comply with recommended interventions.

10. Based on the members risk and willingness to make lifestyle changes, tailored education/counseling, intervention, and referrals will be made with follow up.

C. Providers will be provided.

1. Access to appropriate IHEBA tools and educational materials in English, Spanish. Forms in other languages will be provided as they are developed by the DHS.

2. Training in the use of the tool to ensure appropriate implementation of the IHEBA. A training sign-in sheet will be utilized at all training sessions and individual orientations, and PCPs will be required to sign-in.

3. Reminder information about IHEBA processes and timelines at least annually.

D. Oversight of the correct usage of the IHEBA will be conducted during the medical record portion of a facility site review (FSR). The FSR database will be queried biannually to determine the percent of providers utilizing the tool appropriately.

E. The QM committee will review queries and determine when additional in-services and/or written instructions for PCPs are required.

F. Reports will be submitted to health plans in the formats and timeframes required.

FORMS

Staying Healthy Assessment Tool in English

REFERENCE:

Medi-Cal Managed Care Policy Letter 13-001

Community Legal Aid SoCal

Advocates for Justice in Orange and Los Angeles Counties



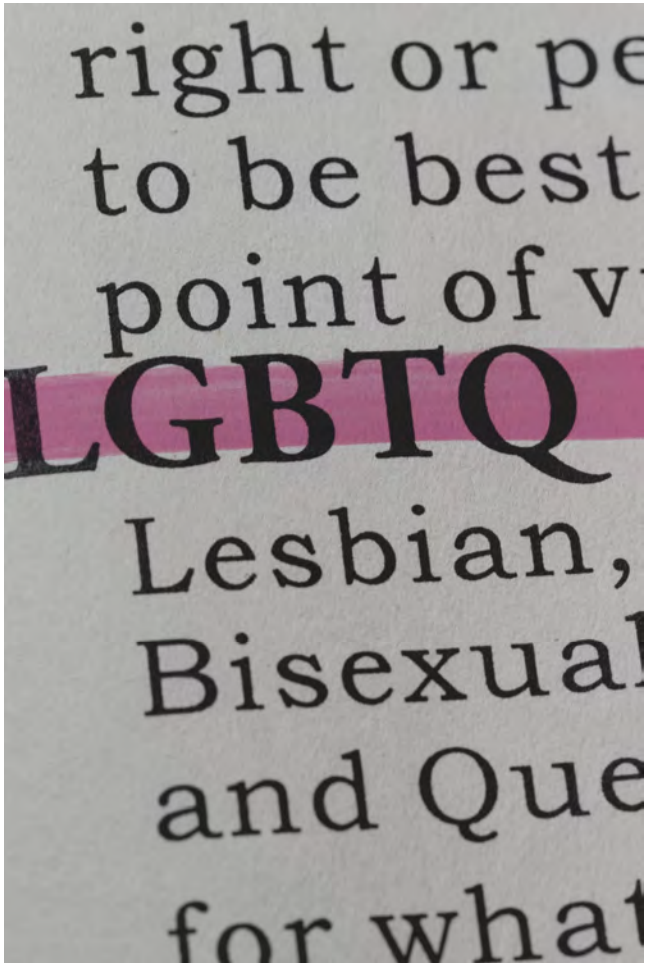
Improving Gender-Affirming Health Care

"Gender-Affirming Care is health care that holistically attends to transgender people's physical, mental, and social health needs and well-being while respectfully affirming their gender identity".

Reisner SL, Radix A, Deutsch MB. Integrated and gender-affirming transgender clinical care and research. J Acquir Immune Defic Syndr. 2016;72:S235–42.

Community Legal Aid SoCal

Advocates for Justice in Orange and Los Angeles Counties



LGBTQ+ is a Diverse Community

- Lesbian
- Gay
- Bisexual
- Transgender
- Queer

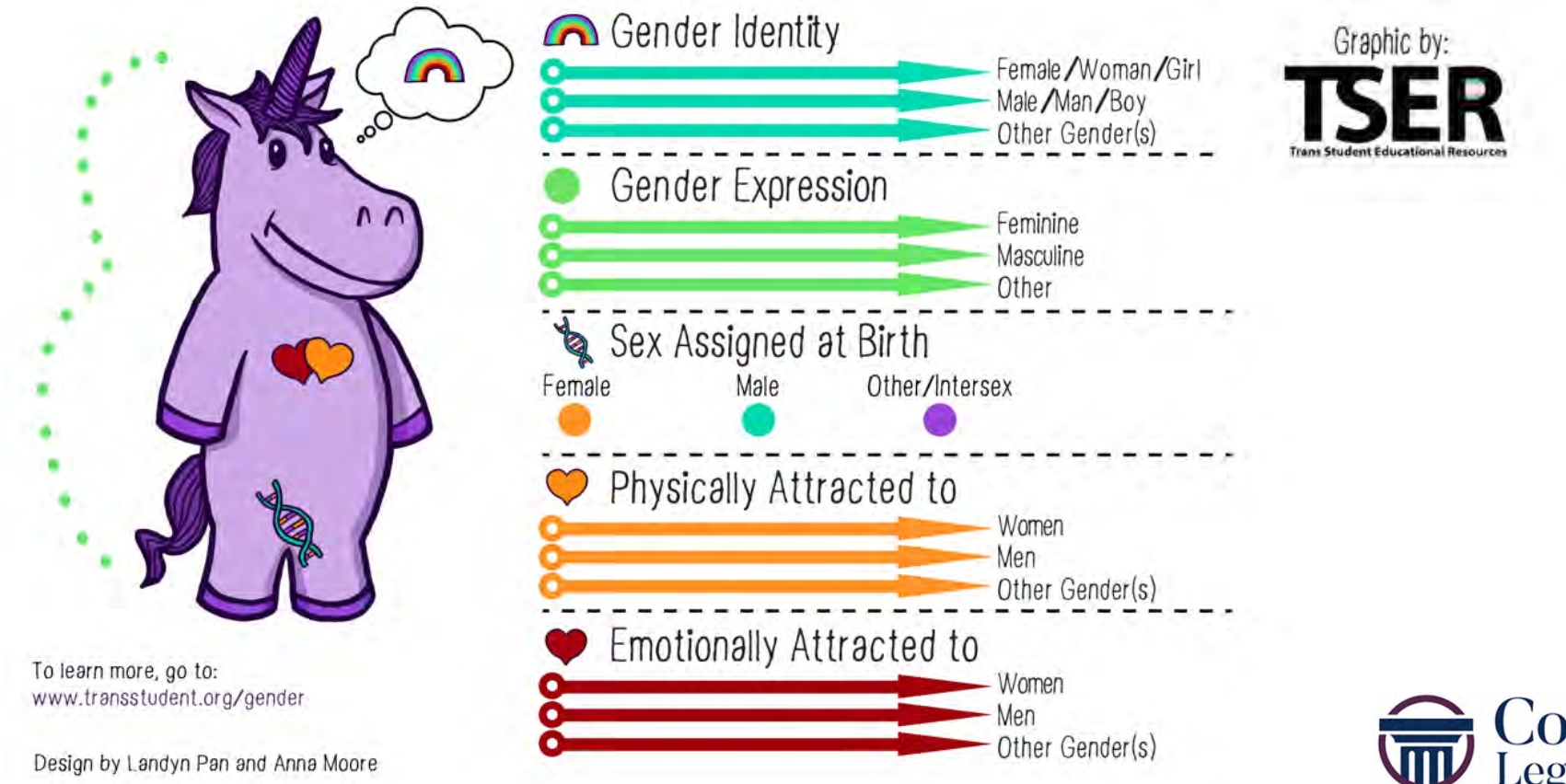
Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

Gender Identity is Different than Sex

- **Sex** is a label — male or female — that you're assigned by a doctor at birth based on the genitals you're born with and the chromosomes you have. It goes on your birth certificate.
- **Gender identity** is how you feel inside and how you express your gender through clothing, behavior, and personal appearance. It's a feeling that can begin very early in life.
- **Gender** is much bigger and more complicated than assigned sex. Gender includes gender roles, which are expectations society and people have about behaviors, thoughts, and characteristics that go along with a person's assigned sex.

Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

The Gender Unicorn



Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

The Difference Between Sex and Gender Identity



Health care providers need to understand that there are differences:

- There are transmen who have uteruses and need GYN care.
- There are transwomen who have prostates and need screening.

Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

Take a Moment to Hear Why Some Physicians are Afraid of Transgender Patients



Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties



Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

LGBTQ+ Enrollees Want to be WELCOMED



- They want to see LGBTQ+ people pictured on the plan website and in brochures.
- They want to be able to easily find providers who offer gender-affirming care and related resources.
- They want to fill out forms that allow them to indicate the appropriate pronouns by which they want to be referred.

Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

LGBTQ+ Enrollees Want to be RESPECTED

- They do not want to be subjected to inappropriate comments.
- They do not want to be questioned about their mental health when seeking gender-affirming care.



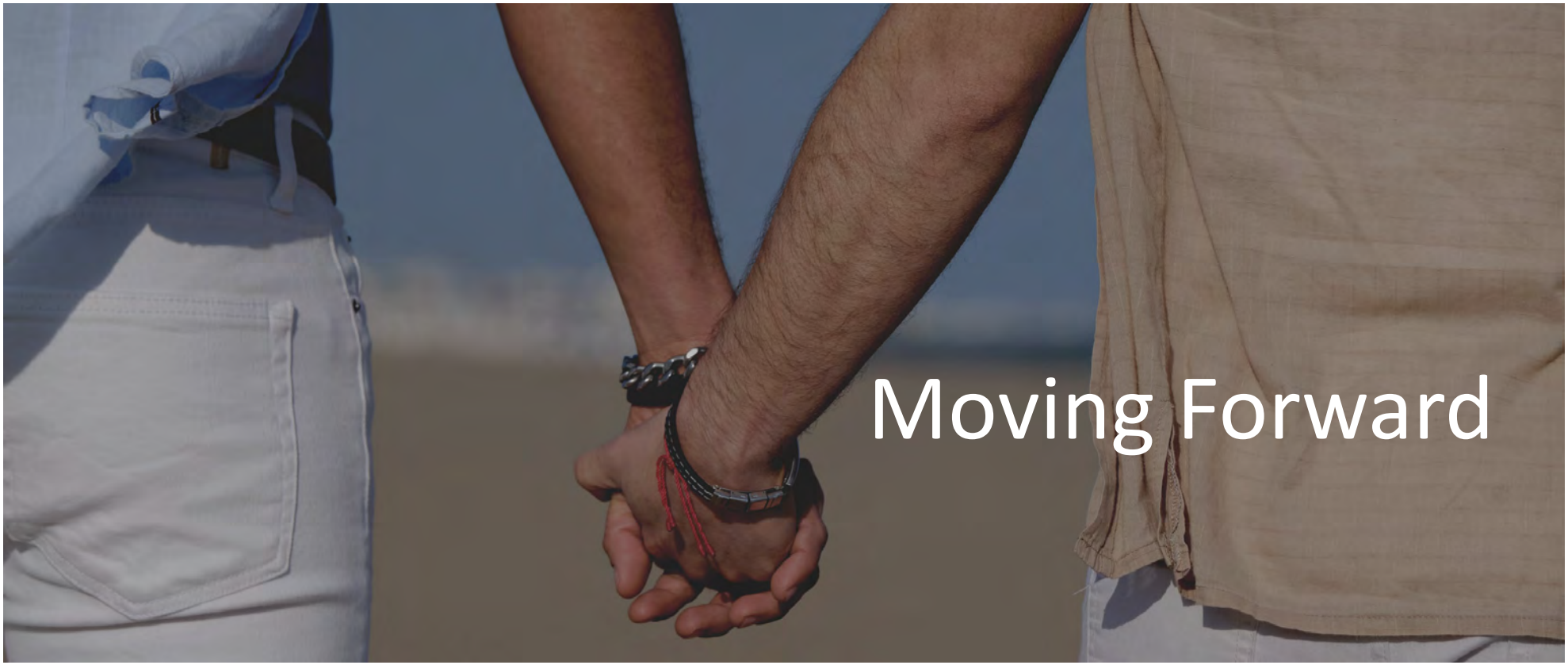
Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

LGBTQ+ Enrollees Want to be CARED FOR PROPERLY



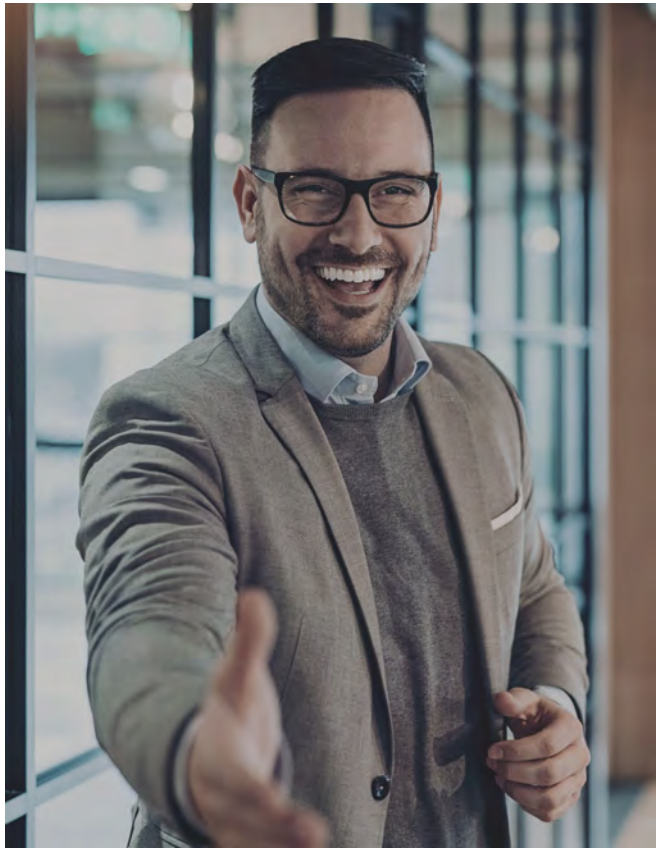
- By local gender-affirming care providers.
- Given referrals to out-of-network providers who are properly vetted.
- Transported out-of-network by professional vendors who are culturally sensitive.
- Receive approval of care recommended by out-of-network providers consistent with APLs and WPATH guidelines.
- Have access to case managers who can assist them in navigating the health care system.

Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties



Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

Recommendations to Ensure Enrollees are WELCOMED



- Review websites, brochures, and documents to improve inclusiveness and sensitivity.
- Create a welcoming environment with visual signs of affirmation.
- Utilize cultural sensitivity training for all staff and network providers.

Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

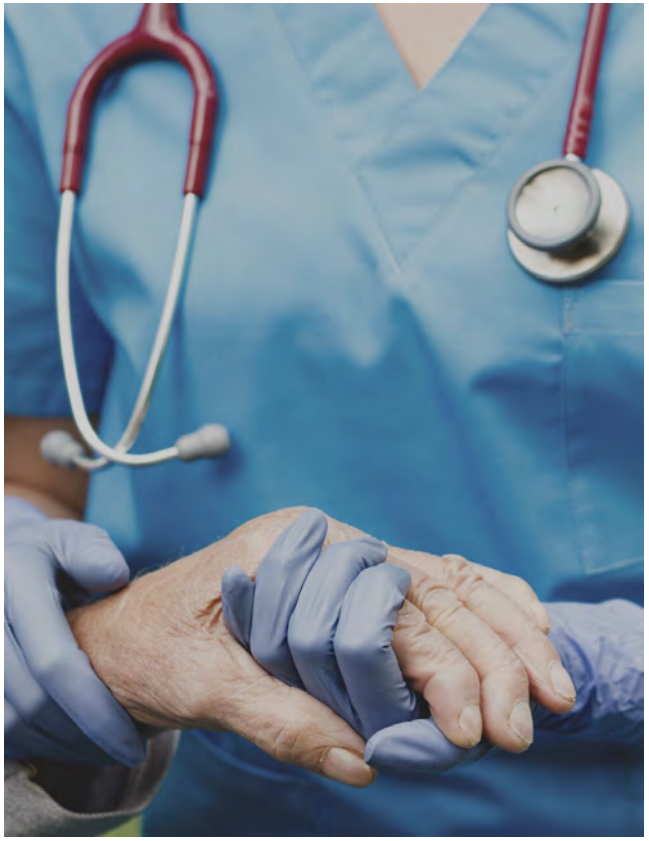
Recommendations to Ensure Enrollees are RESPECTED



- Ask a person their chosen name and pronouns, and then use those. It's an act of basic respect.
- Encourage training and certification of providers in gender-affirming care through WPATH.
- Establish an LGBTQ+ task force which includes LGBTQ+ organizations and enrollees.
- Publish an annual report on the status of providing quality gender-affirming care.

Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

Recommendations to Ensure Enrollees are PROPERLY CARED FOR



- Develop a local network of gender-affirming care providers.
- Review procedures for contracting with out-of-network physicians to properly select experienced gender-affirming care providers.
- Establish an LGBTQ+ case manager who can assist provider networks coordinate care for enrollees.
- Annually update staff and providers on laws, regulations, and APLs.

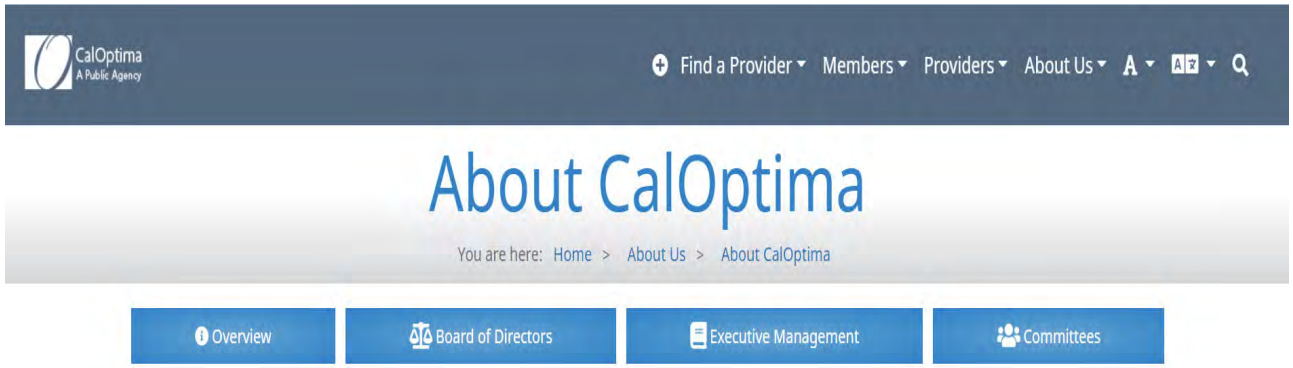
Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties



Why Does this Matter?

Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties

It Matters Because…

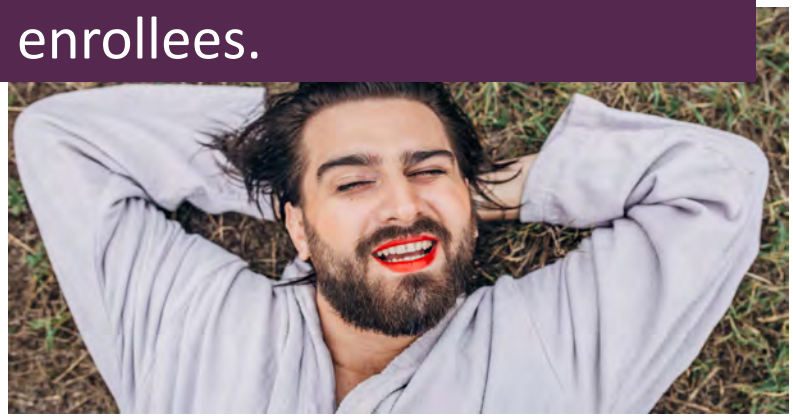


Community Legal Aid SoCal
Advocates for Justice in Orange and Los Angeles Counties



Together, we can improve gender-affirming care for CalOptima enrollees.





Community Legal Aid SoCal

Advocates for Justice in Orange and Los Angeles Counties

Visit Us on the Web

www.communitylegalsocal.org

HEALTHSMART MANAGEMENT SERVICES, INC.

SUBJECT: Member Rights, Protections and Responsibility Policy# M.S. 7008
DEPARTMENT: Member Services

Effective Date: December 2014
Last Revision Date: May 2015; June 2017; June 2018; May 2019; May 2021
Last Review: January 2023

SCOPE:

This policy applies to Medicare & Medi-Cal lines of business.

PURPOSE:

To ensure members are aware and guaranteed their rights and protections. Member rights include but are not limited to, those rights and protections provided by 42 CFR 438.10, 42 CFR 422 Subpart C and the CFAM-MOU.

POLICY:

All members must be guaranteed their right to the following:
1. Right to be treated with dignity and respect.

2. Right to be afforded privacy and confidentiality in all aspects of care for all health care information, unless otherwise required by law.

3. Right to be provided copy of his or her medical records, upon request, and to request corrections or amendments to these records.

4. Right to not be discriminated against based on race, ethnicity, national origin, religion, sex, age, genetic information or source of payment.

5. Right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

6. Right to access to an adequate network of primary and specialty providers who are capable of meeting the member needs with respect to physical access, and communication and scheduling needs, and are subject to on-going assessment of clinical quality including required reporting.

7. Right to choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.

8. Right to participation in all aspects of care and to exercise all rights to appeal. This includes but is not limited to the right to freely exercise his or her rights without adverse effect on the way a provider or its contractors treat the member.

9. Right to file an Appeal if services are denied that the member feels are medically indicated and to have an independent external system of review.

10. Right to receive medical and non-medical care from a team that meets the member's needs in a manner that is sensitive to the member's language and culture in an appropriate care setting including the home and community.

11. Members have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end.

12. Receive a comprehensive health risk assessment upon date of coverage in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, including an evaluation of the members strengths and weaknesses, and a plan for managing and coordinating the member's care. A member or their designated representative, also have a right to request re-assessment by an interdisciplinary care team, and be fully involved in any such reassessment.

13. Right to be provided information on all programs services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, and in consideration of member's condition and ability to understand.

14. Right to translation of services available to make information appropriately accessible.

15. Right to elect a representative and/or caregiver and/or family member in treatment discussions and decisions.

16. Right to receive advance notice, in writing, of any transfer to another treatment setting and the justification for transfer.

17. Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

18. Right to receive information timely regarding plan changes. This includes but is not limited to, the right to request and obtain information listed in the orientation materials once a year and the right to receive notice of any significant change in the information provider in the orientation materials at least 30 days prior to the intended effective date of a change.

19. Right to be protected from liability for payment of any fees that are the obligation of the plan or Medical Group which the member is assigned.

20. Right to not be charged any cost sharing for Medicare Part A and B services, when applicable. Members shall not be balanced billed by provider. If provider balance bill member, provider will be contacted and educated to not balance bill member. Provider will also be mailed a letter notifying them of the guidelines of balance billing members.

21. The unconditional and exclusive right to hire, fire, and supervise his or her In Hone Support Services provider, where applicable.

22. Right to receive their Medicare and/or Medi-Cal appeals rights in a format and language that is easily understood and accessible.

23. For CalMediConnect members, the right to opt out at any time, beginning at the first of the following month.

REFERENCES
A. Title, 42, CFR 483.100, 42 CFR 422 subpart C, CFAM-MOU

SUBJECT: Delegation Oversight for Facility Site Reviews **Policy #**: QM16
DEPARTMENT: Quality Management

Effective Date: January 2005
Last Revision Date: February 2007
Last Review: January 2023

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define the process for oversight of a contracted vendor to assure that full scope site reviews are conducted according to state standards.

POLICY:

All delegated entities shall follow the most current MMCD site review policy requirements and contracted health plan policy requirements for site reviews of PCPs.

Vendor shall perform a Full Scope Site Review at all sites, unless instructed otherwise by IPA.

All site review shall be performed utilizing the most current version of the DHS MMCD Site Review Survey and Medical Record Review Survey.

Site review personnel from delegated entities shall be trained, certified, and supervised according to the policy standards established by the health plans.

IPA and contracted vendor shall be responsible for establishing a formal, mutually agreed upon document that identifies specific delegated functions.

DEFINITIONS:

Full Scope Site Reviews: An onsite inspection to evaluate the capacity or continuing capacity of a PCP site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.

Medical Record Review Survey: The DHS survey tool for review of medical records that includes, but is not limited to, format, legal documentation practices, documented evidence of the provision of preventive care, and coordination of primary care services.

MMCD – Managed Medi-Cal Division of the Department of Health Services (DHS).

PCP Site: A building, office, suite, facility, or site in which a PCP provides covered services to a member.

Primary Care Physician (PCP): A physician who is responsible for supervising, coordinating, and providing initial and primary care to members, initiating referrals, and maintaining the continuity of member care under a managed healthcare system.

Site Review Survey: The DHS survey tool for onsite Full Scope Site Reviews.

PROCEDURE:

A. Reports

1. Site and Medical Record Review

    a. Vendor will submit copies of all facility site reviews, medical record reviews, corrective action plans, follow-up reviews and correspondence with provider and/or office manager.

    b. Copies will be filed within provider files. Copies will be made if multiple providers are at one site.

2. Monthly reports

    a. Contracted vendor shall submit a monthly report of all sites reviewed for the past 30 days. This report shall contain all the data elements listed in the attached CalOptima Data Dictionary.

    b. Credentialing coordinator shall enter data into a database if report data cannot be uploaded into present site review database.

    c. Once data is entered, IPA shall run a report to determine whether any recurring trends are noted. Trends may include, but not be limited to:

        1. Most or all sites reported receive a greater than 90% score with no critical element, pharmacy or infection control deficiencies.

        2. Most or all sites reported receive a score lower than 80%.

    d. Any trend that is apparent for at least three months shall result in a 1:1 meeting between the vendor and the VP of Medical Management.

        1. Based upon that meeting, corrective action, if required shall be identified and implemented.

        2. All trends, and resolutions, shall be reported to the Quality Management Committee.

B. Staff

1. Vendor shall be required to perform inter-rater reliability tests on all employees at least annually. Reports of these performances shall be sent to IPA.

2. Vendor shall assure that all site reviewers attend annual DHS/ LA County/Orange County inter-rater reliability inservices. Reports of these shall be sent to IPA.

C. Provider Feedback
   1. Surveys
      a. Provider surveys shall be reviewed for trends and/or problems with site reviews and/or site reviewers.
      b. Corrective action shall be implemented as noted in D.1.a and b

   2. Grievances
      a. Provider grievances shall be reviewed for trends in problems with site reviews, and/or site reviewers.
      b. Corrective action shall be implemented as noted in D.1.a and b

D. Corrective Action

   1. Any trend that is apparent for at least three months shall result in a 1:1 meeting between the vendor and the VP of Medical Management.
      a. Based upon that meeting, corrective action, if required shall be identified and implemented.
      b. All trends, and resolutions, shall be reported to the Quality Management Committee
   2. Continued identification of similar trends may result in termination of the vendor's contract.

FORMS:

Full Scope Site Review Survey (CA DHS MMCD) (Attachment A)
Medical Record Review Survey (CA DHS MMCD) (Attachment B)

REFERENCES:

Medi-Cal Managed Care Division (MMCD) Policy Letter 02-02

SUBJECT: Quality Improvement Projects **Policy #: QM17**
DEPARTMENT: Quality Management

Effective Date: April 2015
Last Revision Date: April 2019
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To provide a method for identifying, developing, approving, and implementing Quality Improvement Projects (QIPs).

POLICY:

The Quality Improvement Projects (QIPs) are designed to measure and evaluate the performance of important clinical and non-clinical areas. These projects would objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care, and timeliness by which they are delivered to IPA members. These procedures provide an opportunity to continuously improve and resolve performance issues within the organization.

The Quality Improvement Projects (QIPs) are aligned accordingly with Health Plan's QI Program. This includes Pay for Performance (P4P) Programs for HEDIS measurement sets, as well as Health Network Initiatives. The QIPs are selected based on relevance for their member demographics and health status of their service population. For example, for the Whole Child Program, data on Pediatric plan performance standards developed by DHCS to measure health outcomes of children with special health care needs may be utilized to assess.

The QI Committee (QIC) oversees the implementation, monitoring, and evaluation of all QI activities.

PROCEDURE:

The Quality Improvement Projects (QIPs) represent initiatives and processes that are approved and implemented to achieve target performance goals based on established benchmarks and applicable standards.

Initiatives and outreach activities are integrated into all aspects of the organization and assigned to appropriate staff within the different departments. This includes disease management, utilization management, provider services, member services, and credentialing. Adequate data sources and statistical analysis are utilized to meet the program needs and goals.

The QIP updates are reported to the IPA's Board of Directors, and project initiatives and activities are evaluated and updated at least annually and/or whenever necessary.

FORMS:
None required.

SUBJECT: Provider Preventable Condition **Policy #:** QM19
DEPARTMENT: Quality Management

Effective Date: October 25, 2017
Last Revision Date: October 25, 2018
Last Review Date: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define process for identifying and reporting Provider Preventable Conditions [PPCs].

DEFINITIONS:

Provider Preventable Conditions are categorized as follows:

Category 1 – Health Care-Acquired Conditions-HCACs (For Any Inpatient Hospitals Settings in Medicaid)

- Foreign objects retained after surgery.
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma, resulting in fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock.
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor glycemic control, including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
- Surgical site infection following:
  - Coronary artery bypass graft (CABG) - mediastinitis
  - Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery.
  - Orthopedic procedures; including spine, neck, shoulder, elbow.
  - Cardiac implantable electronic device (CIED) procedures
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement **with pediatric and obstetric exceptions.**
- Iatrogenic pneumothorax with venous catheterization

Category 2 – Other Provider Preventable Conditions-OPPCs (For Any Health Care Setting)

- Wrong surgical or other invasive procedure performed on a patient.
- Surgical or other invasive procedures performed on the wrong body part.
- Surgical or other invasive procedure performed on the wrong patient.

CMS further defined OPPCs as conditions that 1) are identified by the State plan; 2) are reasonably preventable through the application of procedures supported by evidence-based guidelines; 3) have negative consequence for the beneficiary; 4) are auditable; and 5) include, at a minimum, the procedures listed in Table 1.

POLICY:

As of July 1, 2012, CMS stopped making payments for HCACs that occur in an inpatient setting or for OPPCs that occur in any health care setting, except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider.

PPCs may be identified through review including but not limited to Concurrent Review process, UM process, Case Management process, and/or monthly encounter data review.

Education to Medical Directors, Physician Reviewers and MSO Staff on identification of PPCs will occur annually and for new staff upon new hire.

Upon identification of any PPC, the case will be immediately reported to the member's health plan following the plan's required process for reporting.

- If the health plan requires direct report of PPC to DHCS, reporting will be done by using the secure online reporting portal. Instructions for the online portal can be found at:
  - http://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx
- A copy of all submission will be maintained along with the log.

All PPCs will be logged and reported to the Quality Management Committee.

REFERENCE:

APL 17-009
DPL 17-002

SUBJECT: Annual Face-to-Face Encounter **Policy #:** QM20
DEPARTMENT: Quality Management

Effective Date: January 2023
Last Review Date: January 2026

SCOPE:

This policy applies to Special Needs Plan lines of business.

PURPOSE:

To define process for identifying and reporting Annual Face-to-Face Encounters

POLICY:

Effective January 1, 2023, CMS requires a face-to-face encounter for the delivery of health care or care management or care coordination services and be between the member and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff, or contracted plan health care provider within the first twelve (12) months of enrollment into a Special Needs Plan and at least on an annual basis, and as feasible with the member's consent.

Documentation of outreach efforts to members will be maintained. The Primary Care Physician will document the reason this annual encounter cannot be performed, including but not limited to:

- Member refusal to consent.
- Non-response to outreach attempts
- The state of the member's health does not allow them to participate, such as being hospitalized in an out of network facility.

A face-to-face encounter must be either in person or through a visual real-time, interactive telehealth encounter. Telephonic or other audio-only encounters do not meet the fulfillment of a face-to-face encounter.

The annual face-to-face encounter can be performed by:

1. Primary Care Physician
2. Specialist related to member's chronic condition.
3. Behavioral Health Care provider
4. A contracted health plan provider
5. A member of the Interdisciplinary Care Team, including but not limited to Managed Long-Term Services and Supports (MLTSS) provider – as long as this provider is a member of the ICT, part of the plan's care coordination staff, or a contracted health plan provider.
6. Health educator
7. Social Worker

Encounters that quality are face-to-face visits for one of the following:

1. Annual Wellness visit or physical.
2. Health Risk Assessment (HRA) completed in person or via virtual telehealth.
3. Encounter for overall health including functional status.
4. Encounter to engage member to oversee their health care including but not limited to health-related education.

5. Encounters addressing mental/behavioral health.
6. Encounters for overall health including functional status and
7. Engagement with the enrollee to oversee their health care.

DEFINITIONS:

Feasibility Standard: CMS included an "as feasible" standard within the regulation to allow for compliance even if the member cannot be engaged so long as the SNP has made reasonable, documented efforts. This feasibility standard does not include having to provide reasonable accommodation, such as interpreter services, as a qualifying reason not to complete this encounter.

Face-To-Face Timeliness: The face-to-face encounter must occur within the first 12 months of enrollment with the plan and at least annually thereafter. Delegates should use the date of the most recent annual face-to-face visit as the date from which to measure when another annual face-to-face visit is due.

PROCEDURE:

1. The Primary Care Providers are notified of their newly eligible members monthly. The PCP is responsible for reaching out to the members to set appointments for annual wellness exams.

2. A report of SNP members not seen to date is sent quarterly to the PCPs for additional outreach and efforts for Annual Assessment.

3. The PCPs are responsible to make continuous good faith efforts to reach the member to coordinate their annual assessment and ensure a minimum annual face-to-face encounter occurs by PCP or accepted provider type.

4. Health Plans may require a monthly/quarterly report for notification/monitoring of annual face-to-face visit compliance, monitoring to completion. The report is prepared from review of Claims encounter data to assess dates of encounters meeting face-to-face requirement in comparison to each enrollee's effective date and annually thereafter.

    a) For purposes of this face-to-face requirement, the reporting will address face-to-face encounters that occurred by any contracted health provider, PCP, Specialist, Behavioral Health, Health educator, Social Worker, or member of the member's Interdisciplinary Care Team for any qualifying encounter.

    b) The report will track and include the reason the annual encounter was not performed.

    c) The report will be submitted in a timely manner according to the health plan's requirements.

REFERENCE:

Code of Federal Regulations 42CFR422.101(f)(iv)

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

M5: HEDIS MEASURES AND REPORTING

OVERVIEW

HEDIS® stands for the Health Care Effectiveness Data and Information Set, which is a set of standardized measures developed by the National Committee for Quality Assurance (NCQA) to evaluate consumer health care. It allows for assessment based on quality and performance. Altogether, HEDIS consists of 96 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 and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare Advantage members.

CalOptima is required to report HEDIS rates to the California Department of Health Care Services (DHCS), CMS and the NCQA annually. Data obtained from HEDIS helps CalOptima to direct its quality improvement activities, evaluate performance and identify further opportunities for improvement. HEDIS measures are also selected by DHCS as quality measures for 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 hybrid by NCQA, CalOptima also collects and reviews medical records.

- From late February to early May, the contracted copy service contacts provider offices to retrieve medical records. Abstractors review the medical records to determine if the member received the service required for the numerator. If the service is not documented, further research is done to determine if CalOptima received a complete chart from the provider's office or if a different office should be contacted to obtain additional records.

Why Is it Important to Members and Practitioners? Measuring health care services allows CalOptima to develop initiatives to improve the health of members based upon their health care needs. Quality programs serve to increase member awareness and understanding of preventive health care, health care screenings and appropriate care for specific conditions. Throughout the HEDIS data collection process, CalOptima maintains every member's confidentiality at the highest level following all Health Insurance Portability and Accountability Act (HIPAA) regulations.

HEDIS Tips for Practitioners

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

- Practitioners should keep accurate, legible and complete medical records for their patients. Each document in the medical record must contain the member name and date of birth (DOB) to be acceptable for HEDIS. If paper charts are used, the member's full name and DOB should be documented on every page (front and back).
- 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 the NCQA for compliance, practitioners and their staff should become familiar with HEDIS measures to understand what health plans are required to report.

Frequently Asked Questions (FAQ) Regarding Medical Record Collection

We submit claims and encounters; why does CalOptima need medical records?

- HEDIS requires us to provide data to calculate the quality of care for different measures. Examples of these measures include diabetes care, immunization status, prenatal and postpartum care and controlling blood pressure. Some of the data required is not available on the claims submitted by providers and other health care partners. We can obtain it only through chart reviews.

What is my responsibility in the data collection process?

- HEDIS is a time-sensitive project. It is very important that providers respond to the requests for medical record documentation in a timely manner to ensure CalOptima can report complete and accurate rates. The contracted HEDIS vendor will contact the provider office to establish a date for on-site, fax, upload to their secure website or mail data collection. CalOptima will supply the provider office with a patient list so the requested medical records can be made available for the on-site visit or for faxing/uploading/ mailing the documentation. If a member on the list is a member that has not been seen in the provider's office, providers may indicate "Patient Never Seen" next to the name on the list and return the form to the contracted vendor.

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 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 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 representative or designated vendor for HEDIS data collection?

- Yes. As a CalOptima business associate, providers are permitted to disclose protected health information (PHI) to the contracted vendors who are acting on CalOptima'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 members sign a medical records release form at the time of enrollment so that it is not necessary for a practitioner to obtain a release. The following link provides more information about the HIPAA privacy rule: www.hhs.gov/

What can I expect if my member(s) have been selected for Medical Record Review?

- After contacting the provider office to verify the fax number, the copy service company will fax the provider a letter of representation, list of member's names for whom we will need medical records, along with HEDIS Measures Records Needed Document to help with the record retrieval process. Please work directly with the copy service to coordinate the retrieval method (fax, upload, mail or on-site scanning). If those options don't work for the provider office, they may notify CalOptima immediately, and we will work with the provider office to accommodate their needs.
- If a provider office has transitioned or is in the middle of transitioning to an electronic medical record (EMR), notify the copy service and assist them in locating the service in the EMR. Providers should be familiar with their EMR. Make sure that all pertinent information is properly displayed when printing. For example, if providers know they can enter the height and weight and the system automatically calculates the body mass index (BMI) but it's not displayed when the progress note prints out, providers may take a print screen of the data entry and submit it to CalOptima along with the medical record.
- If the practice has more than one location and providers are aware the member was seen at the other locations, please forward the request to the appropriate office and notify the copy service.
- If dates of service are missing or additional information is needed to accurately reflect the services rendered, CalOptima may call to confirm if the office has the appropriate information.

If providers have questions about HEDIS measures or data collection, call CalOptima's Provider Resource Line at **714-246-8600**.

Protecting Your Family's Health
Noble Mid-Orange County
888.880.8811

c/o HealthSmart Management Services Organization, Inc.
Mailing: P.O. Box 6300, Cypress, CA 90630-0063
Phone (714) 947-8600; Fax (714) 947-8752

March 25, 2023

«PCP»

IMPORTANT!
Mandatory response REQUIRED. Please SUBMIT your 2021 PPE forms by DECEMBER 31, 2021

Re: 2021 Preventative Physical Examination (PPE Form) for MEDICARE MEMBERS

Dear Provider:

YOUR MEDICARE PREVENTATIVE PHYSICAL EXAMINATION FORMS FOR 2021 ARE READY

TOTAL POTENTIAL INCENTIVE: $«Potential_Incentive»

If you have already performed an Annual Physical Exam, please fax your **2021 COA** forms to **(714) 947-8752**.

$120 per form submitted by December 31, 2021

PREVENTATIVE PHYSICAL EXAMINATION (PPE) Submission Fax Number:
(714) 947-8752

If you have any questions, please contact me directly at **(714) 947-8652**. Thank you for your continued support.

Sincerely,
On behalf of Noble Mid-Orange County
HealthSmart Management Services Organization, Inc.

Erik Banados, Associate Vice President, Provider and Member Outreach

Noble Mid-Orange County

2023 HEDIS/PREVENTIVE PHYSICAL SERVICES (PPE)

Fax to: (714) 947-8752

DATE OF EXAM:_____

PCP: _____

Member Name _____ **DOB** _____ **SEX** _____

Marital Status _____ **Children** _____ **Lives with** _____

Home telephone _____ **Mobile** _____ **Primary Language** _____

Caregiver (CG) _____ **CG contact** _____ **Interpreter Assistance** _____

IPA _____ **HEALTH PLAN** _____ **ID#** _____

Z00.00 (**w/o** abnormal finding)
or
Z00.01 (**w/** abnormal finding)

PHYSICAL EXAM/ANNUAL WELLNESS/PREVENTION PLAN ☐ **SEE ATTACHMENT**

☐ **G0402: Initial** Preventive Physical Examination or Welcome to Medicare visit.
This can only be billed in the first twelve months of enrollment in Medicare.

☐ **G0438: Initial** Annual Wellness Visit paid only once in a patient's lifetime.
*This can only be billed **after** the first 12 months of enrollment in Medicare.*

☐ **G0439:** All **subsequent** Annual Wellness Visits.

Height _____ **Weight** _____ **BP** _____

Mental Status	☐	**Intact**	☐	**Oriented**	☐	**Confused**	☐	**Impaired memory**	
Behavior Status	☐	**Cooperative**	☐	**Depressed**	☐	**Suicidal**	☐	**Combative**	
Elder Abuse	☐	**None**	☐	**Physical**	☐	**Mental**	☐	**Sexual**	

Vision Acuity **L** _____ **R** _____

3008F ★ **BMI** _____ ☐ **Normal** ☐ **Under-WT** ☐ **Over-WT** ☐ **Obese**

ADVANCED DIRECTIVE ☐ **1157F: AD IN CHART** ☐ **1158F: AD DISCUSSED**

4004F Tobacco Use Yes ☐ No ☐ **Drug Use** Yes ☐ No ☐ **Alcohol Use** Yes ☐ No ☐

Received advice to quit YES ☐ NO ☐

Cessation medication were recommended and discussed YES ☐ NO ☐

Cessation method were recommended and discussed YES ☐ NO ☐

PAST MEDICAL HISTORY/SOCIAL HISTORY

_____ _____

_____ _____

_____

CURRENT MEDICAL HISTORY/SOCIAL HISTORY

ICD-10	Description	Can condition be currently diagnosed?	Additional ICD-10 Codes
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	

Member Name: _____ **DOB:** _____ **ID:** _____

PAST HOSPITALIZATION AND SURGERY ☐ **NONE**

Date	Diagnosis	Date	Diagnosis	Date	Diagnosis

CURRENT MEDICATION REVIEW ★ ☐		**1160F: RX REVIEW and 1159F: RX LIST**	
Medication	**Last Reported DOS**	**Is patient currently taking medication?**	**Additional Medications**
		YES ☐ **NO** ☐	
		YES ☐ **NO** ☐	
		YES ☐ **NO** ☐	
		YES ☐ **NO** ☐	
		YES ☐ **NO** ☐	

Drug Allergy **YES** ☐ **NO** ☐

Date of Medication Reconciliation Post Discharge __/___/____ ☐ **1111F: MRP** **Must be between 30 days after discharge**

Annual monitoring for patients on persistent medication

ACE inhibitor/ARB/ Diuretics: BMP Result __/__/___

Digoxin: Digoxin level and BMP ___/____/____

Review completed for potentially harmful drug-disease interactions in the Elderly (check if applicable):

☐ History of falls and prescription for anticonvulsants, nonbenzodiazepine hypnotiocs, SSRIs, antiemetics, antipsychotics, enzodiazepines or tricyclic antidepressants.

☐ Dementia and prescription for antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 Receptor antagonists, nonbenzodiazepine hypnotics or anticholinergic agents

☐ CKD and prescription for Cox-2 Selective NSAIDs or nonasprin NSAIDs

AVOID HIGH RISK RX	☐	**Discuss: High risk medication. See comprehensive list at** www.ncqa.org/Portals/0/Newsroom/SOHC/Drugs_Avoided_Elderly.pdf **Note: PCP should have no more than 5% of their members who have received 2 or more high risk medications Rx filled.**
RX ADHERENCE HTN	☐	**Discuss: RX adherence of ACEI, ARB and Renin inhibitor**
RX ADHERENCE Lipid **RX CARDIOVASCULAR DISEASE**	☐	**Discuss: RX adherence for statin (Adherence over 80%)**
RX ADHERENCE DM	☐	**Discuss: RX adherence for oral glycemic RX.**
RX ADHERENCE DM	☐	**Discuss: Statin therapy for patients with diabetes (Adherence over 80%)**

G0444-3725F DEPRESSION SCREENING * PHQ-9 Scoring

☐ YES ☐ NO See PHQ-9 below * See below PHQ-9 scores & diagnosis

Over the past 2 weeks, how often have you had the following problems:	**None**	**Several days**	**> 1/2 of the Day**	**Nearly Every Days**
1. Little interest or pleasure in doing things	☐ **0**	☐ **1**	☐ **2**	☐ **3**
2. Feeling down, depressed or hopeless	☐ **0**	☐ **1**	☐ **2**	☐ **3**
3. Recurrent insomnia, or sleeping too much	☐ **0**	☐ **1**	☐ **2**	☐ **3**
4. Feeling tired or having little energy	☐ **0**	☐ **1**	☐ **2**	☐ **3**
5. Poor appetite or overeating	☐ **0**	☐ **1**	☐ **2**	☐ **3**
6. Feeling bad about yourself	☐ **0**	☐ **1**	☐ **2**	☐ **3**
7. Trouble concentrating on things	☐ **0**	☐ **1**	☐ **2**	☐ **3**
8. Moving or speaking so slowly or the opposite	☐ **0**	☐ **1**	☐ **2**	☐ **3**
9. Thoughts of better off dead or of hurting self	☐ **0**	☐ **1**	☐ **2**	☐ **3**

ADD TOTAL SCORE TOGETHER **DIAGNOSIS**

PHQ-9 SCORE	**DIAGNOSIS**	**PHQ-9 SCORES**	**DIAGNOSIS**
5-9	Minimal Symptom	10-14	Major Depression, Mild
15-19	Major Depression, Moderate	>20	Major Depression, Severe

☐ **G8510 SCR CLIN DEPR NEG F/U PLAN NOT REQUIRED** ☐ **G8431 SCR CLIN DEPR POS & F/U PLAN DOCUMENTED**

☐ G8433 SCR CLIN DEPR NOT DOC/PT NOT ELIGIBLE

Member Name: _____ **DOB:** _____ **ID:** _____

1170F FUNCTIONAL ABILITY/SAFETY SCREENING ★

☐	YES	☐	NO	Do you need help with bathing, dressing, toileting, transferring, feeding?
☐	YES	☐	NO	Do you need help w telephone, transportation, shopping, preparing meals, housework, laundry, toileting, feeding, medications or managing money?
☐	YES	☐	NO	Unsafe rugs in hallway, lack grab bar in bathroom, lack handrails on stairs or poor lighting?
☐	YES	☐	NO	Problem with judgment (e.g. making decision, problem w thinking)
☐	YES	☐	NO	Repeats same things over and over (questions, stories, statements)
☐	YES	☐	NO	Forget correct month or year
☐	YES	☐	NO	Any hearing vision or speech problems?
☐	YES	☐	NO	Referral for any of above problem

3288F FALL RISK SCREENING

☐	YES	☐	NO	Have you fallen in the last 12 months?
☐	YES	☐	NO	Do you feel unsteady, dizzy or shuffle when you walk or when you stand up?
☐	YES	☐	NO	Do you feel weaker than you used to?
☐	YES	☐	NO	Risk intervention

1090F URINARY INCONTINENCE SCREENING

☐	YES	☐	NO	Do you leak urine?
☐	YES	☐	NO	Do you dribble urine even after you've finished urinating?
☐	YES	☐	NO	Do you experience frequency (day or night), urgency?
☐	YES	☐	NO	Referral for urinary incontinence evaluation

PAIN SCALE EVALUATION ★ ☐ **1125F (Have pain)** ☐ **1126F(No Pain)**

	☐ 0	☐ 1 ☐ 2	☐ 3 ☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9	☐ 10
Verbal	No	Mild pain		Severe pain	Worst
Activity	No	Can be ignored	Interferes with task	Interferes w basic need	Rest

Location	☐	Head	☐	Neck	☐	Back	☐	Chest	☐	Abdomen	☐ Extremities

DISEASE MANAGEMENT

☐ **Fall Prevention-Advice/brochure given to Member**

☐ **Glaucoma Exam: Vision screening & glaucoma screening** >65 YO by optometrist/ophthalmologist.
Screening Date: _____/_____/_____ Name of optometrist/ophthalmologist:_____

☐ **Monitor Physical Activity – advice given**
- **Inquiry Date for Member's Level of Physical Activity: ___ /___ /___**
- **Exercise: _____ mins/day, _____days/week**
- **Suggestion to Member about exercise level:**

To increase _____ , To maintain _____

☐ **Improving bladder control – advice/brochure given**

☐ **COPD Exacerbation Control (per episode):**
- **COPD Exacerbation Date: ___ /___ /___**
- **Steroid Rx Date (within 14 days of each episode): ___ /___ /___**
- **Steroid Rx Name: _____**
- **Bronchodilator Rx Date (within 30 days of each episode): ___ /___ /___**
- **Bronchodilator Rx Name: _____**

☐ **94014 Spirometry Date of service of Spirometry:_____**

COPD ☐ **Chronic Bronchitis** ☐ **Bronchial Asthma** ☐ **Bronchiectasis** ☐ **___/___/_____**

☐ **Alcohol Dependence – Treatment and Follow-Up:**
- **Date of Initial Diagnosis: ___ /___ /___**
- **Initial Tx Date: ___ /___ /___**

☐ **Drug Dependence – Treatment and Follow-Up**

☐ **Avoiding Hospital In-Patient Re-admissions:**
- **Hospital Discharge Date: ___ /___ /___**
- **PCP Follow-Up Date: ___ /___ /___**

☐ **Mini-COG Test Date: ___ /___ /___ Result: _____**

Member Name: _____ **DOB:** _____ **ID:** _____

DISEASE SPECIFIC CARE PLAN		GOALS & MANAGEMENT PLAN	LAST DOS
BP & LIPID DISEASE ★ 18-75 YO (<140/90)	☐ **3074F**	**Systolic BP < 130 mm Hg**	**Date: ___ /___ /___**
	☐ 3075F	Systolic BP 130-139	
	☐ **3077F**	Systolic BP >=140	**BP reading: _____**
	☐ **3078F**	**Diastolic BP < 80 mm Hg**	
	☐ 3079F	Diastolic BP 80-89	LAST DOS
	☐ 3080F	Diastolic BP >= 90	
DIABETES MELLITUS ★ diabetes (Types 1 and 2) must **complete all 3 Exams in 2020:** **1. HBA1C Lab Test 2.Micro-albumin Lab Test 3. Dilated Retinal Eye Exam**	☐ 4010F	ACE/ARB FOR HTN/DM	LAST DOS
	☐ **83036 HbA1c Screening**	**Lab Provider Name:**	LAST DOS in 2020
	☐ **83036 HbA1C Screening and 3044F Result HbA1c level <6.9%**	**Lab Provider Name:**	LAST DOS in 2020
	☐ **83036 HbA1C Screening and 3051F Result HbA1c level 7.0-7.9%**	**Lab Provider Name:**	LAST DOS in 2020
	☐ **83036 HbA1C Screening and 3052F Result HbA1c level 8.0-9.0%**	**Lab Provider Name:**	LAST DOS in 2020
	☐ **83036 HbA1C Screening and 3046F Result HbA1c level 9.0% and Greater**	**Lab Provider Name:**	LAST DOS in 2020
	☐ **82042 Microalbumin Screening**	**Lab Provider Name:**	LAST DOS in 2020
DM Retinal Exam Dilated Retinal Eye Exam performed by Ophthalmologist or Optometrist ★	☐ **99213**	☐ **2022F With Evidence of Retinopathy** ☐ **2023F Without Evidence of Retinopathy**	**Name of Ophthalmologist or Optometrist:** LAST DOS in 2020
			RESULT ☐ **Normal 3072F** ☐ **Retinopathy**

Vaccines	☐ 90732	☐ Z23	Pneumococcal (1 per life)	LAST DOS		
	☐ 90658	☐ Z23	Influenza (Yearly)	LAST DOS		
Mammogram ★ **50-74 YO (10/01/2018 to 12/31/2020)**	☐ 77065	☐ Z12.31	☐ **Mammogram Referral Submitted**	**Imaging Provider Name:**		LAST DOS in 2020
	☐ 77066	☐ Z12.31				
	☐ 77067	☐ Z12.31		**RESULT** ☐ **Normal** ☐		**Abnormal**
Colon Cancer Screening 50-75 Years Old ★ DRE not accepted by HP, FOBT must be submitted to Lab	☐ 82270 **FOBT (Completed yearly)**	☐ Z12.11	**Lab Provider Name:**			LAST DOS in 2020
	☐ 81528 **FIT DNA Test**	☐ Z12.11	**Lab Provider Name:**			LAST DOS in 3 Yrs
	☐ 45330 **Sigmoidoscopy**	☐ Z12.11	☐ **Colonoscopy Referral Submitted**	**Service Provider:**		DOS Last 5Y
	☐ 45378 **Colonoscopy**	☐ Z12.11		**Service Provider:**		DOS Last 10Y
				RESULT ☐ **Normal** ☐		**Abnormal**
RA Management	☐ 4187F	☐ M06.9	Pt recvd at least one DMARD **(must be filled for compliance)**	LAST DOS		
Bone Mass W 67+ w fracture	☐ 77080	☐ M84.40XA	DXA scan (axial)	LAST DOS		
	☐ 4005F		Anti-osteoporosis RX **(must be filled for compliance)**	LAST DOS		

☐ **Patient received personalized health advice and referral, as appropriate**.

PHYSICIAN'S SIGNATURE & CREDENTIALS **DATE**

PHYSICIAN'S NAME & CREDENTIALS

☐ Discussed Benefits Members Member requests CM ☐ YES ☐ NO

ORANGE COUNTY PHYSICIANS IPA MEDICAL GROUP, INC. DBA NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY
c/o Healthsmart Management Services Organization, Inc.
Mailing: P.O. Box 6300, Cypress, CA 90630-0063
Phone (714) 947-8600; Fax (714) 947-8752

CONFIDENTIAL HEALTH INFORMATION

This transmission contains health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

June 25, 2023

Re: Updated Medicare 2021 ICD10 HCC Superbill-Charge Ticket that includes TELEHEALTH for Encounter Data Submission

Dear Noble Community Medical Associates Physician:

Noble Community Medical Associates is pleased to announce an update to their Medicare HCC Superbill. Physicians are eligible for a $10 incentive for each superbill faxed or entered on the Ehealthcare portal for your Medicare Members. You may submit multiple superbills throughout the year capturing all conditions, but will only be reimbursed for one Superbill per patient, per month. **INCLUDES A NEW TELEHEALTH BOX.**

Noble Community Medical Associates has a $10 Incentive per month for each completed Superbill faxed or Submitted via Ehealthcare Portal:
https://secure.prod.hsmso.net/hsmso.net/login.aspx
(One per Medicare Patient, per month)

We recommend you evaluate all chronic conditions from the member's charts and carefully document the diagnoses with the correct ICD-10 codes using the enclosed HCC Superbill. You may add new chronic conditions that may not be previously addressed. Please keep a copy in your charts for your records. The Superbill must have the date of service and must be signed by the Physician, and **fax your Superbills to (714) 947-8752**.

Please be advised that all submitted encounter data and completed via Telehealth, you must mark the **TELEHEALTH BOX – Place of Service 02, PCP MUST USE VIDEO AND AUDIO during their communication with the patient.**

Thank you for your continued support in providing quality care to our members. If you have any questions, please contact me directly at 714-947-8652.

Sincerely,

On behalf of Noble Community Medical Associates, Inc. of Mid-Orange County
HealthSmart Management Services Organization, Inc.
Erik Banados, VP of Provider & Member Outreach

Warning: This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.

ORANGE COUNTY PHYSICIANS MEDICAL GROUP, INC. **FAX TO 714-947-8752**
dba NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. of MOD-ORANGE COUNTY

PHYSICIAN: _____ **Date of Service:** _____ **HMO:** _____
PATIENT: _____ **DOB:** _____ **SEX:** _____ **HMO ID:** _____

NEW PATIENT OFFICE VISIT	CPT [_____] **Select** ☐99202 ☐99203 ☐ 99204 ☐ **TELEHEALTH** *MEDICARE ANNUAL VISIT ☐G0402 INIT ☐G0438 LT ☐GO439 SUBS		
ESTABLISH PT OFFICE VISIT	CPT [_____] **Select** ☐ 99212 ☐99213 ☐ 99214 ☐ 99215 ***PT BMI ICD10:**_____ ☐ **BLOOD PRESSURE**_____/_____		
***CARE OF OLDER ADULT**	☐RX REVIEW AND LIST 1159F & 1160F ☐FUNCTIONAL EVA 1170F ☐MRP 1111F ☐HAVE PAIN 1125F ☐NO PAIN 1126F		

ENDO/METABOLIC	**DMII W UNS COMPLICATIONS E11.8**	**DMII WO COMPLICATIONS E11.9**	**DM W HYPERGLYCEMIA E10.65**
DM UN COND W POLYNEU E08.42	**DM WO COMPLICATIONS E10.9**	**DMII NEPHROPA E11.21**	**DM W CKD E11.22 *add CKD code**
DMII W KIDNEY COMP E11.29	**DM II RET W ME E11.311**	**DMII W RETINO WO ME E11.319**	**DM II MN W RETI WO ME E11.3299**
DMII PROLI RETI W ME E11.3519	**DMII PROL RET WO ME E11.3599**	**DMII W CATARACT E11.36**	**DMII W OTHER OPH COMP E11.39**
DMII W NEURO UNS E11.40	**DMII POLYNEURO E11.42**	**DMII W ANGIO WO GANG E11.51**	**DMII W ANGIO W GANG E11.52**
DMII W OTHER CIR COMP E11.59	**DM W HYPOGLY WO COMA E11.649**	**DMII W HYPERGLY E11.65**	**DMII W OTHER COMP E11.69**
MALNUTRI MOD E44.0	**MALNUTRI MILD E44.1**	**OBESITY MORBID E66.01**	**LONG TERM USE INSULIN RX Z79.4**
Hyperthyroid E05.90	Hypothyroid E03.8	Gout M10.9	**CACHEXIA R64**
ONCO/HEMATO	**CA ESOPHAGUS C15.9**	**CA GASTRIC C16.9**	**CA COLON ASCEND C18.2**
CA COLON TRANSVER C18.4	**CA COLON DESCEND C18.6**	**CA COLON SIGMOID C18.7**	**CA COLON UNSPEC C18.9**
CA LIVER CELL C22.0	**CA GALLBLADDER C23**	**CA PANCREAS, UNSP C25.9**	**CA UNS BRON OR LUNG C34.90**
CA BREAST C50._____*add location	**CA CERVIX UTERI, UNSP C53.9**	**CA ENDOMETRIUM C54.1**	**CA OVARY C56._____*add location**
CA UTERI C54.9	**CA PROSTATE C61**	**CA KIDNEY RIGHT C64.1**	**CA KIDNEY LEFT C64.2**
CA BRAIN UNS C71.9	**CA THYROID C73**	**CA SEC UNS LYMPH, UNSP C77.9**	**MET TO LUNG C78.00**
MET TO LIVER & BILE DUCT C78.7	**MET TO KIDNEY & PELVIS C79.00**	**MET TO BLADDER C79.11**	**MET TO BRAIN C79.31**
MET TO BONE C79.51	**MET TO BONE MARROW C79.52**	**MET TO BREAST C79.81**	**LYMPHOMA HODGKIN C81.98**
CEN LYMPH, INTR LYMPH C82.52	**LYMPH NON HODG UNS SIT C85.80**	**LYMPHOM NON HODG C85.88**	**LYMPH NON HODG NOS UNS C85.90**
LEUKEMIA ACU LYMPH C91.00	**LYMPH LEU, IN RELAPSE C91.02**	**LEUKEMIA CHR LYMP C91.10**	**LEUKEMIA ACU MYE C92.00**
LEUKEMIA CHR MYE C92.10	**BENIGN NEO MENINGES D32.0**	**OTHER PANCYTOPENIA D61.818**	**NONTHROM PURPURA D69.2**
PRIM THROMBOCYTO D69.49	**THROMBOCYTOPENIA, UNSP D69.6**	**NEUTROPENIA, UNSP D70.9**	Anemia Unsp. D64.9
CARDIOVASCULAR/PULMO	Hypercholesterolemia E78.00	Hyperglyceridemia E78.1	Mixed Hyperlipidemia E78.2
Hypertension I10	**HTN HD W CHF I11.0 *add CHF code I50.**	**CHF I50.____*Add type heart failure**	**HTN HD CKD 1-4 I13.0 *add CKD & HF**
Old CVA Cogni Def Uns I69.319	**HTN CKD5 ESRD I12.0 *add CKD N18.**	**CHRONIC KIDNEY DISEASE N18._____**	**HTN HD CKD5 ESRD I13.2 add CKD & HF**
ASHD NAT COR ART W ANG I25.118	**ASHD NATI COR ART WU ANG I25.119**	**ANGINA UNS I20.9**	**PRIM PULMO HTN I27.0**
DILATED CARDIOMYOPATHY I42.0	**CARDIOMYOPATHY, UNSP I42.9**	**SVT I47.1**	**PAROX ATRIAL FIBRILLATION I48.0**
CHRO ATRIAL FIBRILLATION I48.2	**TYPICAL ATRIAL FLUTTER I48.3**	**ATRIAL FIB UNS I48.91**	**SICK SINUS SD I49.5**
CHF SYST I50.22	**CHF ACUTE CHRO SYSTOLIC I50.23**	**CHF DIASTOLIC, UNSP I50.30**	**CHF DIA I50.32**
CHF NOS I50.9	**CEREBRAL INFARCTION, NOS I63.9**	**NSTEMI I21.4**	**CVA W LEFT HEMIPARESIS I69.354**
CVA W UNS SIDE HEMIPARE I69.359	**ATHEROSSC AORTA I70.0**	**TAA WO RUPTURE I71.2**	**AORTIC ANEU NOS I71.9**
PAD / PVD I73.9	**AORTIC ECTASIA, NOS I77.819**	Old Myocardial Infarction I25.2	Unsp Bacterial Pneumonia J15.9
Acute Bronchitis, Unsp J20.9	**BRONCHITIS CHRO UNS J42**	**EMPHYSEMA, UNSP J43.9**	**COPD W ACU LOW RESP INF J44.0**
COPD W ACU EXACERB J44.1	**ASTHMA COPD J44.9**	**BRONCHIECTASIS, UNCOM J47.9**	**PULMO FIBROSIS J84.10**
GASTROENTEROLOGY	**HEPATITIS B WO DELTA B18.1**	**HEPATITIS C B18.2**	**HEPATITIS CHRO VIRA UNS B18.9**
ESOPH VARI W BLEED I85.01	**HEPATIC FAILURE UNS WO COMA K72.90**	PUD w Hemorrhage K27.4	**PUD W PERFO K27.5**
PUD W HEMORRH PERF K27.6	PUD Uns K27.9	Functional Dyspepsia K30	**CROHN'S DISEASE NOS K50.90**
ULCERATIVE COLI K51.90	IBS with diarrhea K58.0	IBS without diarrhea K58.9	Rectal bleeding K62.5
CHRONIC HEPATITIS, UNSP K73.9	**CIRRHO LIVER NOS K74.60**	**OTHER CHRO PANCREATI K86.1**	Dysphagia uns R13.10
NEPHROLOGY	**ACU RENAL FAILU N17.9**	CKD Stage 1 N18.1	CKG stage 2 N18.2
CKD stage 3 N18.3	**CKD STAGE 4 N18.4**	**CKD STAGE 5 N18.5**	**CKD ESRD N18.6 add 2nd* Z99.2**
2ndary Hyperparathyroidism N25.81	Gross Hematuria R31.0	URI Incontinence R32	**DEPENDENCE DIALYSIS Z99.2**
NEURO/MENTAL	Dementia wo Beh Distur F03.90	Dementia wo Beh Distur F03.91	**DEPENDENCE ALCOHOL F10.20**
HYPNOTIC/ANXIOLY DEPEND F13.20	**SCHIZOPHRE F20.9**	**BIPOLAR DIS CURR UNS F31.60**	**MAJ DEPRESSIVE DIS, MILD F32.0**
MAJ DEPRE DIS RECUR MOD F33.1	**DEPRESS MAJ W PSY F33.3**	**DEPRESS MAJ RECU F33.9**	Anxiety Disorder, Unsp F41.9
PARKINSON'S DISEASE G20	Alzheimer uns G30.9	**MULTI SCLEROSIS G35**	**EPILEP WO EPILEPTICUS G40.909**
PARAPLEGIA UNS G82.20	Paresthesia Of Skin R20.2	Syncope And Collapse R55	Old CVA wo Eff Z86.73
RHEUMATO/ORTHO	**STAPH ARTHRI POLY M00.____add 5th & 6th**	**PYOGENIC ARTHRITIS UNS M00.9**	**RHEUMA ARTHRI NOS M06.9**
KAWASAKI DISEASE M30.3	**SYST LUPUS ERYTH ORGA M32.10**	**DERMATOPOLYM ORG M33.90**	**POLYMYALGIA RHEU M35.3**
Polyosteoarthritis uns M15.9	**ANKYLO SPONDYLI UNS M45.9**	Cervical Stenosis M48.02	Spinal Stenosis unspecified M48.00
PATH FRACT LUMB INI M48.56XA	Cervicalgia M54.2	Low Back Pain M54.5	Fibromyalgia M79.7
DERMATO	**DMII W FOOT ULC E11.621 add 2nd***	**FOOT ULCER SITE L97.4 L97.5_**	Dermatitis uns L30.9
DMII W SKIN ULCER E11.622 add 2nd*	**SKIN ULCER SITE L97.1 L97.9_**	**SKIN ULCER SITE L98.4____L98.49_**	**CHRO SKIN ULC, UNS SIT L98.499**
Cellulitis, Unspecified L03.90	Dermatitis, Unspecified L30.9	Psoriasis, Unspecified L40.9	Acne Vulgaris L70.0
PATIENT'S STATUS	**AMPUTA GRT TOE UNS Z89.419**	**AMPUTA TOES UNS Z89.429**	**AMPUTA FOOT Z89.439**
AMPU BELOW KNEE UNS Z89.519	**AMPU ABOVE KNEE UNS Z89.619**	**TRACHEOSTOMY Z93.0**	**GASTROSTOMY Z93.1**
COLOSTOMY Z93.3	**NEPHROSTOMY Z93.6**	**LIVER TRANSP STATUS Z94.4**	**PRESENCE HEART ASSIST DEVICE Z95.811**
INFECTIOUS	**PULMO MYCOBAC INFEC A31.0**	**SEPSIS, UNSP ORGANISM A41.9**	**SEVERE SEPSIS W SHOCK R65.21**
OTHER ICD 10			

PHYSICIAN'S SIGNATURE DATE FOR INTERNAL USE ONLY – -HCC SUPERBILL -2021v2

CREDENTIALING & RE-CREDENTIALING PROCESS

NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY

Credentialing

Physician must comply with all aspects of Noble's credentialing and re-credentialing policies and procedures to satisfy established credentialing and re-credentialing standards in accordance with NCQA guidelines and other regulatory agencies.

Physician will provide a completed application, copies of Professional's license to operate, other accrediting body's certificate, or other documents as necessary to Noble and Plan in a timely manner.

Physician must comply with all applicable federal, state or municipal statutes or ordinances, all applicable rules and regulations of the Medical Board of California and the ethical standards of the American and California Medical Associations.

Physician must advise Noble of each malpractice claim field against Physician and each settlement or judgement of a malpractice claim entered into by Physician within fifteen (15) days following said filing, settlement or judgement.

Physician must notify Noble immediately, in writing, should his/her/they/them Drug Enforcement Agency Number be revoked, suspended or restricted.

As part of the credentialing process, Physician must grant Noble permission to gain access to any and all information, records, summaries of records, reports, files or data relative to Physician's professional qualifications, Professional's mental or physical health, or the quality of care rendered by Professional from any hospital, governmental or private agency or association (including the National Practitioner Data Bank and the Medical Board of California) or any other entity or individual.

Physician must provide Noble with any authorizations, consents or releases which IPA may require from Professional to obtain the information described above. In addition, Physician grants Noble permission, for and on behalf of Physician, to authorize representatives of DHS/DMHC/HMOs contracting with Noble to obtain the information described above.

Forms:

- Minimum Physician Standards
- California Participating Practitioner Application (CPPA)
- Mid-Level Provider Application
- PL 14-004: Facility Site Review and Medical Record Review

For additional information, please visit:

- HealthSmart MSO: http://healthsmartmso.com/hsmso-services/credentialing/

SUBJECT: Credentialing Policy & Procedure – Physicians **Policy #:** CR 1
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 14, 1997
Revised: February 2005; September 2005; January 2006; August 2006; February 2007; March 2007; January 2008; April 2008; January 2009; May 2009; January 2010; January 2011; January 2012; January 2013; January 2014; April 2014; September 2014; January 2015; April 2015; July 2015; January 2016; February 2016; August 2016; January 2017; January 2018; January 2019; April 2019; July 2019; January 2020**, January 2021, January 2023**

PURPOSE:

To describe the credentialing criteria and performance standards that licensed health care providers must meet to ensure satisfactory quality of care and service for participation in the IPA's provider panel.

POLICY:

Policies are reviewed periodically and annually.

Credentialing will be performed after a Minimum Physician Standard Attestation form is completed to identify and assess risk to ensure that the pre-requisite of credentialing standard and the policies are followed as an audit mechanism process used for credentialing for all contracted providers participating in or applying to participate in the IPA provider panel. This includes the following:

Medical Doctors - M.D.
Doctors of Osteopath - D.O.
Doctors of Dental Medicine, Surgery - D.D.S. & D.M.D.
(excluding dentists who provide only primary dental care)
Doctors of Podiatry - D.P.M.
Chiropractors - D.C.
Optometrists – O.D.
Clinical Psychologists – Ph.D.
Non-Physician Behavioral Health – L.M.F.T., M.F.C.C., L.C.S.W.
Audiology – Au.D. and Hearing Aid Dispensers – H.A.
Speech-Language Therapists – S.L.P.
Occupational Therapists – O.T.
Physical Therapists – P.T.

All Utilization Management Practitioners, Medical Directors, UM Physician Reviewers, and /or designees making medical decisions in their scope of practice are credentialed.

Providers who work exclusively within an inpatient hospital setting (e.g., pathologists, radiologists, anesthesiologists, hospitalist and emergency room providers) are not subject to this policy.

Providers who work exclusively within freestanding facilities and provide care for a member only because of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency) are not subject to this policy.

Covering Providers (e.g., locum tenens) who do not have an independent relationship with the IPA;

Providers who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer) are not subject to this policy.

For Medicare lines of business: The IPA will not employ or contract with providers that have Opted Out of Medicare or appear in the OIG Exclusion Database.

Non-discrimination Policy: No aspect of IPA participation shall be denied on the basis of origin, religion, race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes, or physical or mental impairment that does not pose a threat to the quality of patient care.

An applicant is eligible for acceptance as a primary care provider and/or specialty care provider if the provider has met an established set of criteria that will aid in demonstrating their ability to provide quality care to the group's members. The IPA requires that all information used for the credentialing process be primary source verified within one-hundred-and-eighty (180) days of the QM/Credentialing Committee review.

The credentialing process is currently part of the Quality Management Plan. The Medical Director is substantially involved in the development and implementation of the Plan and is a voting member of the QM/Credentialing Committee. The Medical Director has direct responsibility for, and participation in, the credentialing process, including matters that require expert review and special consideration.

Providers must submit to Provider Services all requested credentialing materials and maintain compliance with all criteria as a condition of continued participation in the Group.

CREDENTIALING SYSTEM CONTROLS

PRIMARY SOURCE VERIFICATION INFORMATION

The credentialing applications are **received** via (mail, email, fax, and/or electronic application from online portal CAQH) and supporting documents (ie: Primary Source Verifications received via website query, mail, email, and fax that is stored in a secured badge entry file room).
Once the application is **received** by the credentialing staff, the application is **date** stamped received by Credentialing Assistant, Credentialing Lead and/or Credentialing Coordinator for tracking and processing. **The application received date is tracked** via eHealth Database/System from the attestation date of the signature and date signed by the practitioner for completion within the 36 months or 180day timeframe and by the credentialing checklist used to process the application. The practitioner applications are **stored** in a Manila folder labeled by Practitioner Name, Degree, Specialty, and IPA group stored in a secured badge entry locked Credentialing file room.

PROCEDURE:

The following procedures will be followed for purposes of credentialing. The credentialing staff will check the application for completeness and verify the information. All supporting documents must be attached. If incomplete, the practitioner will be notified via written communication requesting all missing items. Upon receipt of a complete application, the credentialing staff will enter information contained in the application into the data management system.

TRACKING MODIFICATIONS

If the application is incomplete, the practitioner will be notified via written/verbal communication (mail, email, fax or phone) requesting all missing items or information from credentialing application. Upon receipt of the information the credentialing staff will complete the following:

- The Credentialing staff will date stamp and Initial when information was received and modified
- The Credentialing staff will notate how the information was received and modified via Memo to file or placing the submitted forms received with changes by the provider for his/her application updates or missing information
- The Credentialing staff making the modification(s) or change(s) will initial and date all forms submitted by provider(s)
- The Credentialing staff will provide a clear reason noted in a memo to file as to why the information was updated, modified or changed

AUTHORIZATION TO MODIFY INFORMATION

The Credentialing Department Management Level (Credentialing A.V.P, Director, Manager, Supervisor, Lead, Coordinators and /or Credentialing Assistant are the Only authorized staff to access, modify and Delete information from the eHealth data system/credentialing checklist, provider application as appropriate by written or verbal communication only as instructed from the provider/practitioner(s). **Under No** circumstances can anyone **Delete** information from a provider/practitioner application(s). Only memo(s) can be added to the provider/practitioners(s) application for information that needs to be added to the application because it was missing or a correction is needed because of primary source verification has something different ie (start date, end date, etc.) from what the practitioner has provided on the application and/or left off the application for completeness.

System generated re-credentialing applications are updated/modify during reappointment time if information has changed, ie (moved locations, phone/fax number updated, office hours changed etc.) this will be changed, modified, or saved as history.

Upon receipt of a complete application, the credentialing staff will enter information contained in the application into the data management system.

Upon reviewing a provider's credentialing application, if it is noted that they have a mid-level provider (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist or Certified Nurse Mid-Wife) working for them, a credentialing application will be sent to the mid-level provider and tracked until the application is received back in the credentialing department. For the credentialing of mid-level practitioners, please refer to Policy CR 10 Credentialing/Recredentialing Policy & Procedure – Mid-Level Practitioners.

- Physicians must submit mid-level provider licensure to the IPA prior to allowing these professionals to treat managed care members. All appropriate licensures and certifications must be current.
- The supervising physician has continuing responsibility for all medical services provided by the health professional under his or her supervision.
- PAs may perform medical services set forth by the regulations of the MBC when the services are rendered under the appropriate supervision of a licensed physician.
- At all times the supervising physician must be physically or electronically available to the PA for consultation, except in emergency situations.
- The supervising physician must not supervise more than two (2) PAs at one time.
- The supervising physician must not supervise more than four (4) NPs at one time.
- NPs who prescribe drugs and/or devices must be in accordance with standardized procedures or protocols developed by the NP and supervising physician.

- At all times the supervising physician must be physically or electronically available to the NP for consultation, except in emergency situations.

A. Signed Application and Credentials Authorization and Release Form

1. All providers applying to contract with the IPA must complete, sign and date a California Participating Physician Application which includes a Credentialing Authorization and Release Form and Attestation Questionnaire and/or the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Application that has a current attestation date. We will accept faxed, scanned, photocopied and pen signatures. Pencils, erasable ink, or stamped signatures will not be an acceptable writing instrument for completing credentialing applications. By attesting to the CAQH and signing the CPPA application the provider:

    a. Attests to the accuracy and completeness of the statements made on the application and information attached to it;
    b. Agrees to maintain the IPA's credentialing criteria; and
    c. Authorizes the release of information relating to his/her qualifications, and agrees to hold harmless all entities who will be providing the requested information in good faith.

2. The provider application must be completed in full and contain statements by applicant regarding:

    a. Reasons for any inability to perform the essential functions of the position, with or without accommodation.
    b. Lack of present illegal drug use
    c. History of chemical dependency or substance abuse
    d. History of loss or investigation, limitation, suspension, revocation, denial, sanction or probationary conditions of Medical License or DEA or voluntary or involuntary relinquishment of Medical License or DEA in any State
    e. History of conviction of or having pled guilty to a criminal offense, [ie. felony or misdemeanor, excluding misdemeanor traffic violations]
    f. History of investigation, limitation, suspension, revocation, denial, sanction or probationary conditions or restrictions of participation in any private, state or federal health insurance program (ie, Medi-Cal or Medicare) or voluntary or involuntary relinquishment of participation in Medi-Cal or Medicare
    g. History of loss or limitation of hospital privileges or disciplinary activity.
    h. Professional liability claims history
    i. Professional liability insurance valid and current
    j. Professional and Practice Services, which includes, but limited to the request of the following items (Please refer to Standard Operational Procedure (SOP) "CCS-CHDP- SPSP":
        1. Child Health and Disability Prevention Program (CHDP)
        2. California Children Services (CCS)
        3. Comprehensive Perinatal Services Program (CPSP)
        4. Other

B. Current valid California License to Practice his/her Profession

1. Must hold and maintain a current and valid California License to practice his/her Profession within the constraints of Section 2113 of the California Business and Professions Code. However, the Credentialing Committee or Medical Director may consider practitioners with license restrictions, so long as the restrictions and limitations on their scope of practice will not hinder the practitioner from complying with his/her contractual and professional obligations.

2. A photocopy of the current unrestricted California License to Practice his/her profession must be submitted with the completed application and maintained in the provider's file.

3. The Credentialing Staff will perform primary source verification with the Medical Board of California or appropriate licensing board through internet access or by phone.

4. If the primary source verification indicates any investigation, limitations on scope of practice, restrictions on licensure, sanctions or other action, the information will be requested from the appropriate licensing board in writing.

C. Current clinical privileges in good standing in a Group approved hospital within the service area in the specialty that provider is being contracted to provide. Hospital must be designated by the practitioner as the primary admitting facility.

1. If the provider has no admitting privileges, a statement confirming coverage for any inpatient work will be included in the file and reasons for the exception documented. Arrangements for the admission and treatment of hospital patients by an approved provider must be established in a written agreement with the covering provider.

2. Exceptions may be granted if the provider's specialty does not typically require admitting privileges (e.g. Allergy, Dermatology, Pathology, Radiology, Optometrists or Chiropractors). However, if they indicate on their application that they have hospital privileges, the privileges will be primary verified during the credentialing process.

3. A letter is sent to the hospital(s) that the provider identifies in his application, along with a signed, dated Credentials Authorization and Release Form or access of the hospital(s) on-line verification website.

D. Current unrestricted DEA Certificate

1. All providers, except non-prescribing providers, must have a valid DEA certificate with a California address. If they do not have a California address on their DEA, then document who will prescribe for the practitioner until they have their California DEA. A photocopy of the DEA Certificate which clearly shows the number and expiration date must be submitted with the completed application. (Chiropractors and Dentists are excluded)

2. The Credentialing staff will verify the DEA within one-hundred-and-eighty (180) calendar days of the QM/Credentialing Committee decision by accessing the DEA website at https://apps.deadiversion.usdoj.gov/webforms/validateLogin.jsp

E. All providers must have completed appropriate education and training for practice in the designated specialty at an accredited facility. Only the highest level of education must be primary verified. If a provider is board certified according to the criteria listed in Item F below, primary source verification of the board certification will meet this criterion. If a provider is not board certified by one of the recognized boards, then the highest level of training is primary verified in writing or verbally directly with the institution(s) where the post graduate medical training was completed, entry in the AMA Master File or AOIA Physician Profile Report.

1. MD's must have, at a minimum, a two-year accredited residency training with a total of three years minimum of internship and residency in the appropriate specialty.

EXCEPTION: A provider who practices as a General Practitioner must have completed at least one year of stateside primary care medicine training or have completed at least one year of non-primary care medicine training in the United States and provide 2 letters of recommendation from other primary care physicians. In addition, general practice

applicants are required to sign an attestation stating that they have been providing primary care services in the last five (5) years and that at least 20% of their practice is devoted to the age group in which they want membership, i.e. adults (18 years of age and older) or pediatric (0-21 years of age). They must also attest to being familiar with and routinely follow standard preventive services, such as CHDP (for pediatrics only) and United States Preventive Task Force (USPTF). General practitioners requesting pediatric members must be CHDP certified.

2. DO's must have completed the appropriate years of accredited residency training in the appropriate specialty.

3. DC's must have graduated from an accredited Chiropractic school.

4. DPM's must have graduated from an accredited Podiatry school and completed a residency, if any.

5. DDS's must have a DDS degree from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and completion of specialty training

6. OD's must have an OD degree from an optometry school accredited by the Council of Optometric Education of the American Optometric Association.

7. PhD's must have graduated from a professional school.

F. Board Certification for Physicians

Effective January 1, 2015, an expired board certification may be used to verify education and training.

1. Board certification for MD's must be awarded by the American Board of Medical Specialties. Primary source verification is done via the internet by accessing ABMS at www.boardcertifieddocs.com. The data on this site is stored in and extracted from the database used to compose The ***Official*** ABMS Directory of Board Certified Medical Specialists.

2. Board certification for DO's must be awarded by the American Osteopathic Association. Primary source verification is done via the internet by accessing The Official Osteopathic Physician Profile Report at www.doprofiles.org

3. Board certification for DPM's must be awarded by the American Podiatric Medical Association. Primary source verification is done via the internet by accessing www.abfas.org for the American Board of Foot and Ankle Surgery (ABFAS) or www.abpmed.org for the American Board of Podiatric Medicine (ABPM).

4. Board certification for DMD's must be awarded by the American Board of Oral Maxillofacial Surgery. Primary source verification is done via www.aboms.org.

5. A contracted physician shall be Board Certified within five (5) years following the date upon which the contracted physician completes his/her residency training.

6. A contracted physician who is first licensed to practice medicine in the United States jurisdiction before January 1, 2008, is exempt from the requirements of this policy.

7. A contracted physician shall, at all times, maintain Board Certification status in order to participate in the CalOptima program unless he/she is exempt from the Board Certification requirements of this policy.

8. If, upon recredentialing, the contracted physician has failed to maintain his/her Board Certification as required by this policy, the IPA shall notify the contracted physician of his/her noncompliance with the requirements of this policy and shall require contracted physician to re-establish Board Certification within six (6) months after receipt of notice from IPA.

9. If the contracted physician fails to re-establish his/her Board Certification within six (6) months after receipt of notice from IPA, IPA shall remove such contracted physician from participating in the CalOptima program and shall reassign affected members.

G. At a minimum, the last five (5) years of work history must be included on the application and/or C.V. Any discrepancies in work history or gaps of six (6) months or more must be explained. Gaps in work history of six (6) months to one (1) year can be verified in writing or verbally. Any gap in work history that exceeds one (1) year must be explained in writing by the provider.

1. The Credentialing Staff reviews the provider's application and/or C.V. for consistency in work history.

H. Current certificate of malpractice insurance

1. Practitioners must maintain one (1) million dollars per case and three (3) million dollars aggregate minimum professional liability insurance coverage in the specialty that the provider is being contracted for.

2. When the certificate of malpractice insurance is received, the Credentialing Staff sends a letter to the insurance carrier requesting verification of the policy to include policy number, limits of coverage, specialty and expiration date.

3. If the malpractice carrier lists any malpractice cases that the provider has not already explained in his/her application, then the Credentialing Staff writes to the provider and asks for his/her explanation with details of the case.

I. Applicant must provide a history of all professional liability claims.

1. If the provider noted on his/her application that he/she has had any malpractice cases, he/she must submit a professional liability action explanation which must disclose date(s) and detail(s) of the incident(s) leading to the suit(s) or settlement(s); date(s) of suit(s) or settlement(s); name of professional liability insurer involved; applicants role in the incident(s); current status in any suit(s) or other legal action (primary, co-defendant, other); subsequent events, to include patient outcome; amount reserved by the insurance carrier for each claim or amount paid as an out-of-court settlement or amount of jury/court award.

J. Primary source verification with the National Practitioner Data Bank to identify any sanctions from Medicare/Medicaid, termination of privileges or malpractice suits.

1. The Credentialing Staff will query and review the NPDB at initial credentialing and recredentialing cycles via the internet at www.npdb-hipdb.hrsa.com.

2. When the query is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.

3. The results of the search are placed in the provider's credentialing file.

K. Primary source verification of State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice (i.e., identify any history of license actions including denials, revocations, terminations, suspension, restriction, reductions, limitations on practice, sanctions, probations and non-renewals. Any history of being charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded or have voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on the eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, any federal program or disclosure by application attestation questions)

1. Federation of State Medical Boards (FSMB) to identify any sanctions from other states for MD's and DO's.

    a. The Credentialing Staff will query and review the FSMB at initial credentialing and recredentialing cycles via the internet at www.fsmb.org.

    b. When the query is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.

    c. The results of the search are placed in the provider's credentialing file.

2. Federation of Chiropractic Licensing Boards' Chiropractic Information Network/Board Action DataBank for Chiropractors.

    a. The Credentialing Staff sends a written request to the board requesting information on any disciplinary activity for the applicant.
    b. When the verification is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.
    c. The results of the search are placed in the provider's credentialing file.

3. State Board of Dental Examiners for Dentists.

    a. The Credentialing Staff sends a written request to the board requesting information on any disciplinary activity for the applicant.

    b. When the verification is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.

    c. The results of the search are placed in the provider's credentialing file.

4. Federation of Podiatric Medical Boards for Podiatrists

    a. The Credentialing Staff sends a written request to the board requesting information on any disciplinary activity for the applicant.

b. When the verification is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.

c. The results of the search are placed in the provider's credentialing file.

5. Individual State licensing board for each type of licensure.

6. Medi-Cal Suspended and Ineligible Provider List

   a. The Credentialing Staff will query and review the Medi-Cal Suspended and Ineligible Provider List at initial credentialing and recredentialing cycles via the website http://www.medi-cal.ca.gov/references.asp
   b. The results of the search are documented on the form entitled "Medi-Cal Suspended and Ineligible Report" and placed in the provider's credentialing file.
   c. The IPA will not contract with a provider who is suspended or ineligible.

7. The Department of Health and Human Services, Office of Inspector General (OIG) Exclusions & Reinstatement Reports

   a. The Credentialing Staff will query and review the OIG Exclusion and Reinstatement Database at initialing credentialing and recredentialing cycles via the website www.oig.hhs.gov.
   b. If a provider is matched, a written request for the provider sanction information is sent to Office of Investigation; Health Care Administrative Sanctions; Room N2-01-25; 7500 Security Blvd., Baltimore, MD 21244-1850.
   c. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
   d. The IPA will not contract with a provider who has been excluded/sanctioned from government programs.

8. Medicare Opt Out Report – for the Medicare line of business - Opt-Out Affidavits Database at data.cms.gov

   a. The Credentialing Staff will access and review the Medicare Opt Out Report at initial credentialing and recredentialing cycles via the website https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z
   b. The results of the search are documented on the form entitled "Medicare Opt Out Report Findings" and placed in the provider's credentialing file.
   c. The IPA will not contract with a provider who has Opted Out of Medicare.

9. The Excluded Parties List System-EPLS (System for Award Management-SAM) Reports
   a. The Credentialing Staff will query and review the SAM (System for Award Management) Database at initial credentialing and recredentialing cycles via the website www.sam.gov.
   b. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
   c. The IPA will not contract with a provider who has been debarred from participating in government contracts.

10. The NPI and Medi-Cal Number

a. The Credentialing Staff will query the NPI and Medi-Cal Number Database via the website https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a

b. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.

c. If a practitioner(s) is/are Not Medi-Cal enrolled the credentialing coordinator will notify the Provider Services representative to notify and provide the practitioner with the website to begin the provider enrollment process directly through DHCS or through its contracted health plan representative. This will include all provider types delineated by DHCS. http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

d. The Credentialing Staff will not complete the credentialing process until the Practitioner(s) have been enrolled. This is for the Medi-Cal contract. (refer to Medi-Cal Registration Memo)

10. CMS Preclusion List

e. The Credentialing Staff will query the CMS Preclusion List database via the website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html currently, the CMS Preclusion List is being submitted to the IPA groups by their contracted health plan.

f. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.

g. The IPA will not contract with a provider who is on the CMS Preclusion List. **CREDENTIALING**

AUDIT PROCESS

All credentialing files for network and/or continued participation are audited by NCQA standards

- ✓ All initial and re-credential applications are audited before approval
- ✓ Audits can only be completed by an A.V. P., Director, Manager, Supervisor and/or Lead of the Credentialing Department
- ✓ Audits are conducted weekly, bi weekly and/or daily before committee review or clean file review for Medical Director signing of approval
- ✓ The A.V.P., Director or Manager over the Credentialing Department has Oversight responsibilities to ensure file audits are completed.
- ✓ The A.V.P., Director or Manager of Credentialing performs a quality review on 5 percent or 10 files of 50 completed or reviewed by the Credentialing Supervisor and/or Credentialing Lead whichever is less.
- ✓ Audit occurs quarterly by the A.V.P., Director or Manager of credentialing to ensure file compliance according NCQA Standards, CMS, MA/CMS, DMHC & DHCS regulatory standards

Elements Reviewed

Initial Practitioners

- ✓ Degree - Specialty – License – DEA – Education Training – Board Certification – Work History – Completeness of Application
- ✓ Claim History – State Sanctions or Restrictions on Licensure – Medicare/Medicaid Sanctions-NPDB – Medicare/Medicaid Sanctions-OIG (CMS/TRICARE/DHCS)– Med-Cal Suspended and Ineligible Report (DHCS)
- ✓ Inability to Perform Essential Functions of the Position – Lack of Drug Use – Loss of License – Loss of Privileges -Malpractice Coverage of Federal Tort Ltr – Attestation – Hospital Privileges (CMS/DMHC/DHCS) – Opt-Out (CMS/TRICARE) – Attestation

Signature Date – Primary Care Providers – Office Site Quality Review and/or PARS for Specialist – Track Days of Completion

Additional Items for Re-credential Practitioners

- ✓ **Include Items above and**
- ✓ Performance Monitoring (CMS/DHCE) – Previous Committee Date (Last Cred Cycle) – Office Site Quality Review for Primary Care Providers and/or PARS for Specialist – Track Days of Completion

L. A prospective provider office on-site visit is required on new Primary Care Providers (PCPs) and high-volume behavioral healthcare practitioners. The visit will include a review of the medical record keeping system and a structured physical site review. If the provider has had a site visit performed by any of the contracted health plans utilizing the DHS Facility Site and Medical Record tool, a copy of the results of this visit will satisfy this criteria. Refer to CR 3 Provider Facility Site Reviews.

1. A PCP is defined as a General Practitioner, Family Practitioner, Internist, Pediatrician, or an OB/Gyn who requests PCP status, who by contract agree to accept responsibility for primary care services.

M. The process used prior to making a credentialing decision includes the following:

1. Acceptable compliance with general initial credentialing criteria.
2. A participating agreement/contract with the Group signed by the applicant.
3. Input/Advice/Comments, etc. from committee members.
4. Availability and accessibility to include:
   a. Minimum of twenty (20) hours each week of regularly scheduled office hours for treatment of patients for a one (1) physician practice and minimum of thirty (30) hours for two (2) or more physicians.
   b. Response time to urgent calls no greater than thirty (30) minutes after notification.
5. Provider is supportive of the philosophy and concept of managed care and the Group.
6. Applicant must agree to permit appropriate Group representatives access to his/her medical records and shall allow the group to secure copies of any needed medical records. Furthermore, the applicant must submit a signed waiver of any and all rights to bring suit or otherwise initiate any legal actions or claim against the Group, related companies, or any officer, director, employee or agent thereof related to the information obtained in relation to the credentialing process.

N. The Medical Director reviews all credentialing files, approving those that meet minimum eligibility requirements (clean files). All files approved by the Medical Director are reflected in the QM/Credentialing Minutes as having been approved without objection on the date of the Medical Director's signature.

O. The following specific exceptions require review & sign-off by the QM/Credentialing Committee.

1. Three (3) malpractice cases over $30,000 within five (5) consecutive years; or
2. One (1) malpractice case over $100,000 within five (5) consecutive years; or
3. Malpractice cases that are repetitive because of type of specific practices.
4. Past, current and pending Medical Board Actions; Business and Professions Code 805 violations
5. Medical Record Review score of less than 80% within two (2) years.
6. Non-compliance with a corrective action plan.
7. Committed a felony or other act involving moral turpitude, dishonesty, fraud, deceit or misrepresentation or is under investigation with respect to such conduct.

P. Practitioner's Rights and Responsibilities

1. The provider is notified, in writing, by the Credentialing staff when presented with a credentialing application, that they have a right to review non-privileged information obtained to evaluate their credentialing application; a right to be informed, upon request, of the status of their credentialing application; and that they have the right to correct erroneous information submitted by another party, provided the information is not peer-review protected. This includes information obtained from outside sources such as liability carriers, Medical Boards, NPDB. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure. Requests are to be in writing via fax or letter to the Director of Credentialing of the IPA and will be responded to within 3 days to arrange a date and time for such review.

2. Providers are notified, in writing, by the Credentialing staff when information obtained by primary sources varies substantially from information provided on the provider's application. Providers will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if the information obtained is not intended for verification of credentialing elements or is protected from disclosure by law. Providers have the right to correct erroneous information by submitting a detailed explanation in writing to the Director of Credentialing of the IPA within fifteen (15) days of notification of discrepancy.

3. Upon receipt of explanation from provider, Credentialing staff will re-verify primary source information under consideration. If primary source information has changed, an immediate correction will be made to credentialing file. If primary source information remains inconsistent, provider is notified in writing via fax or letter requesting proof of correction by primary source within 10 working days. A second re-verification of primary source information will be performed by Credentialing staff. If primary source information remains inconsistent, it will be reviewed at time of presentation to the QM/Credentialing Committee.

Q. The completed file, including all credentialing information, is submitted to the Medical Director, or designee, for review prior to being submitted to the QM/Credentialing Committee. Upon his/her review, the file is then submitted to the QM/Credentialing Committee within one-hundred-and-eighty (180) days of the provider's attestation and dates of primary source verifications for review.

1. If the applicant is approved, the Credentialing Dept. notifies the provider in writing within sixty (60) calendar days.
2. A copy of the appeals process will be provided or made available to the applicant upon request; which in noted on the recruitment cover letter provided to each applicant.
3. If denied, please refer to Denial of Participation Policy (Policy CR 4).

R. QI/Credentialing Committee – The QI/Credentialing Committee is part of the Quality Improvement Committee. Meetings will convene on a monthly basis (minimum quarterly). Members of the committee are rotated annually to assure broad representation but serve staggered two (2) year terms to ensure continuity. The committee has access to board certified specialty physicians who may be asked to join the committee on an ad hoc basis, if needed. The chairperson or designee will facilitate each meeting.

Membership – (voting rights):	Membership – (nonvoting rights):
QM Chairperson	President
Medical Director	Medical Management
Two (2) Primary Care Physicians	Credentialing
One (1) Specialty Care Physician	Member Services
	Contracting/Provider Services

1. The number of members required for a quorum shall be determined to be a minimum of three (3) physicians. Consultation with specialists is an option open to the QM/Credentialing Committee on an as needed basis.

2. The Board of Directors of the IPA has delegated to the QM/Credentialing Committee the authority to review credentialing policies and procedures and to recommend revisions, additions and/or deletions deemed necessary; to perform peer review functions in concert with credentialing; to review and evaluate the qualifications of each applicant and practitioner; and to make credentialing decisions to approve or to deny applicants.

3. A consistent format of minutes will be reviewed and approved by the QM/Credentialing Committee. Recorded separate from other committee agendas, the minutes will be maintained in a binder organized by the most recent date. Minutes of previous meetings will be made available for health plans that request a review. Minutes and other confidential documents may not be removed from the QM/Credentialing office, nor reproduced in any manner and will be kept in a locked area.

S. On a quarterly basis, the Credentialing Committee prepares a report that is presented to the Board of Directors of all providers that have been approved or denied.

T. Other Affiliations

1. No applicant is automatically entitled to participate with the Group merely because he/she is a member of any other contracted IPA, or other professional society, or because he/she had, or presently has, staff membership or privileges at another health facility or in another practice setting, or because he/she is a new member of another group currently under contract with IPA.

U. Continued participation

1. It is the responsibility of the Group's providers to maintain general criteria and to inform the Group of changes in status of any information as a requirement of continued participation. Failure to do so may be grounds for termination.

V. Resignation - A participating provider may officially resign in accordance with the process described in his/her current Primary Care Physician Agreement or Specialist Agreement.

W. Follow-Up Between Credentialing Cycles

1. On a monthly basis, credentialing staff query the existing provider database for sanctions or limitation on licensure, DEAs, malpractice insurances and board certifications that are due to expire within the following month.

2. Credentialing staff requests and obtains current information regarding these documents from each provider.

3. In addition to obtaining hard copies, Credentialing Staff will access the online verification systems for medical license, DEAs and board certification to obtain verifications within thirty (30) days of expiration

X. Delegation of Credentialing/Recredentialing Activities

a. Refer to Memorandum of Understanding for Delegated Activities

PROVIDER DIRECTORIES / MEMBER MATERIALS AND HEALTH PLAN SUBMISSIONS

The Credentialing Department ensures that the information included in Provider Directories and on Provider Profiles for health plan submission is consistent with the information obtained during the credentialing/recredentialing process.

Provider Directories
Provider Directories are maintained by the Credentialing Department and posted on the Intranet for access by internal departments. The Provider Directories are routinely reviewed for accuracy and updated with new information obtained between cycles and at time of recredentialing.

The data listed on the Provider Directories includes, but is not limited to, the following: provider name, degree, specialty/sub-specialty, demographic information (address, phone and fax number), languages spoken by provider and staff, accessibility for people with disabilities, open or closed panel to accepting new members, board certification status, hospital privileges and office hours.

Health Plan Submissions
Upon completion of initial credentialing, the Credentialing Department generates a Provider Profile from the provider database. The provider database contains the information obtained either from the provider's application or approved verification sources. The Provider Profile contains the required data elements for health plan submission. The Provider Profile is sent to the Provider Services Department for submission to contacted health plans as appropriate.

CONFIDENTIALITY:

Each provider will have a confidential file which contains credentialing information as well as quality assurance information, if applicable. Credentialing files for each provider are strictly confidential and are under lock. Any and all information that is not used will be shredded. Access will be limited to the Credentialing Department staff and those individuals designated by the Credentialing Department to participate in the process. Credentialing files are protected from discovery pursuant to Section 1157 of the Evidence Code. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with Section 1157. Quality assurance information will be contained in a separate area of the file. All agendas, minutes, reports and documents presented to the QM/Credentialing Committee are marked as "Prepared for the QIC – This document is confidential as defined by Section 1157 of the California Evidence Code".

To ensure that all staff, QM/Credentialing Committee members and guests adhere to their duty to maintain confidentiality, all employees of the IPA and members of the QM/Credentialing Committee will sign confidentiality statements according to company policy (refer to Policy QM 1 Quality Management Committee).

NON-DISCRIMINATORY CREDENTIALING:

The IPA monitors and prevents discriminatory credentialing through the following processes:

1. Tracking and trending of reasons for denial and/or terminations.
2. Semi-annual audit of files in process for greater than six (6) months to determine compliance with practitioner contract criteria.
3. Periodic audits of practitioner complaints are submitted to determine if there are complaints alleging discrimination.
4. The presence of a nondiscrimination statement on the "Provider Panel Confidentiality Statement" to be signed by UM/QM/Credentialing Committee members.
5. Documents and/or information submitted to the QM/Credentialing Committee for approval, denial or termination do not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, or patient type of procedures performed or payor sources.

ELECTRONIC SECURITY/SECURING INFORMATION:

All electronic data sent or received by the Credentialing Department requires the use of a password in order to be able to access the data. All passwords are maintained in a secure location. All persons involved in receiving electronic data that contains sensitive material that falls under the confidentiality requirements will be assigned a password to receive the data. All credentialing applications and supporting documents/materials, fax machine and scanners are maintained in a secured badge entry file room preventing unauthorized access by any other outside of the credentialing/contracting staff and limited physical access to authorized management staff only.

REPORTING CHANGES IN STAFF

The Credentialing A.V.P., Director, or Manager of the Credentialing Department has the reporting authority to communicate with the appropriate departments. i.e. (HR, IT) with any changes or withdrawal/removal of staff members in the credentialing department for deactivation and/or disabling of employee(s) system access, phone, badges, etc. who are no longer with the organization. System generated request require the credentialing staff to change passwords regularly and/or periodically per system notification. Primary Source Entity accounts are kept in a password protected secure location.

FORMS:

California Participating Physicians Application

REFERENCES:

HSMSO CR 3 Provider Facility Site Reviews
HSMSO CR 4 Denial of Participation
HSMSO CR 10 Credentialing / Recredentialing Policy & Procedure – Mid-Level Practitioners
HSMSO QM 1 Quality Management Committee
HSMSO IS. 14 Physical Access Control
HSMSO IS. 21 System Security Policy
HSMSO IS. 22 User Account Security
HSMSO IS. 28 Authentication and Password
HSMSO IS. 62 Deactivate Employee Access
HSMSO PP HealthSmart Backup and Recovery SITC-HS-B&R-01
MEDI-CAL Registration Memo
NCQA MCO Standards and Guidelines – Credentialing and Recredentialing
CMS Guidelines

SUBJECT: Recredentialing Policy & Procedures – Physicians **Policy #:** CR 2
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 14, 1997
Revised: February 2005; August 2005; January 2006; February 2007; March 2007; January 2008; January 2009; May 2009; January 2010; January 2011; January 2012; January 2013; January 2014; April 2014; September 2014; January 2015; July 2015; January 2016; February 2016; January 2017; January 2018; October 24, 2018; January 2019; April 2019; July 2019; January 2020**, January 2021, January 2023**

PURPOSE:

To describe the recredentialing criteria that must be met by all contracted providers every three years in order to verify that each provider demonstrates satisfactory quality of care and service.

POLICY:

Policies are reviewed periodically and annually.

Recredentialing will be performed for all contracted providers participating in the IPA provider panel. This includes the following:

Medical Doctors - M.D.
Doctors of Osteopath - D.O.
Doctors of Dental Medicine, Surgery - D.D.S. & D.M.D.
(excluding dentists who provide only primary dental care)
Doctors of Podiatry - D.P.M.
Chiropractors - D.C.
Optometrists – O.D.
Clinical Psychologists – Ph.D.
Non-Physician Behavioral Health – L.M.F.T., M.F.C.C., L.C.S.W.
Audiology – Au.D. and Hearing Aid Dispensers – H.A.
Speech-Language Therapists – S.L.P.
Occupational Therapists – O.T.
Physical Therapists – P.T.

All Utilization Management Practitioners, Medical Directors, Physician Reviewers, and/or designees making medical decisions in their scope of practice are recredentialed.

Providers who work exclusively within an inpatient hospital setting (e.g., pathologists, radiologists, anesthesiologists, hospitalist and emergency room providers) are not subject to this policy.

Providers who work exclusively within freestanding facilities and provide care for a member only because of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency) are not subject to this policy.

Covering Providers (e.g., locum tenens) who do not have an independent relationship with the IPA;

Providers who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer) are not subject to this policy.

Non-discrimination Policy: No aspect of IPA participation shall be denied on the basis of origin, religion, race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes, or physical or mental impairment that does not pose a threat to the quality of patient care.

A formal recredentialing process is completed, at a minimum, every three years to ensure the provider has satisfactorily met the recredentialing criteria. All information evidencing compliance with the criteria may not be more than one-hundred-and-eighty (180) days old at the time of QM/Credentialing Committee review.

The recredentialing process is currently part of the Quality Management Plan. The Medical Director is substantially involved in the development and implementation of the Plan and is a voting member of the QM/Credentialing Committee. The Medical Director has direct responsibility for, and participation in, the recredentialing process, including matters that require expert review and special consideration.

PROCEDURE:

One-hundred-and-twenty (120) days prior to a provider's recredentialing due date, the Credentialing staff will send to provider a pre-completed CPPA Recredentialing application. The provider is asked to review and update the information currently on file in the Credentialing Department. The provider is then given a fifteen (15) day time period to complete and return the Recredentialing application. If not returned within twenty-one (21) days, a second letter sent via certified mail, return receipt requested is sent asking for his compliance with the Recredentialing request outlining that noncompliance could be grounds for suspension or termination from the Group.

When the Recredentialing application is received in the Credentialing Department, the staff will check for completeness and verify the information. All supporting documents must be attached. If incomplete, the practitioner will be notified via written communication requesting all missing items. Upon receipt of a completed Recredentialing application, the Credentialing staff will update the data management system.

A. Signed Recredentialing Application and Credentialing Authorization and Release Form

1. All providers that are contracted with the IPA/Medical Group must complete, sign and date a California Participating Physician Application which includes a Credentialing Authorization and Release Form and Attestation Questionnaire and/or the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Application that has a current attestation date. We will accept faxed, scanned, photocopied and pen signatures. Pencils, erasable ink, or stamped signatures will not be an acceptable writing instrument for completing credentialing applications. By attesting to the CAQH and signing the CPPA application the provider:

    a. Attests to the accuracy and completeness of the statements made on the recredentialing application and information attached to it;
    b. Agrees to maintain the IPA/Medical Group's credentialing criteria; and
    c. Authorizes the release of information relating to his/her qualifications, and agrees to hold harmless all entities who will be providing the requested information in good faith.

2. The Recredentialing Application must be completed in full and contain statements by the provider regarding:

    a. Reasons for any inability to perform the essential functions of the position, with or without accommodation.
    b. Lack of present illegal drug use
    c. History of chemical dependency or substance abuse
    d. History of loss or investigation, limitation, suspension, revocation, denial, sanction or probationary conditions of Medical License or DEA or voluntary or involuntary relinquishment of Medical License or DEA in any State
    e. History of conviction of or having pled guilty to a criminal offense, [ie. felony or misdemeanor, excluding misdemeanor traffic violations]
    f. History of investigation, limitation, suspension, revocation, denial, sanction or probationary conditions or restrictions of participation in any private, state or federal health insurance program (ie, Medi-Cal or Medicare) or voluntary or involuntary relinquishment of participation in Medi-Cal or Medicare
    g. History of loss or limitation of hospital privileges or disciplinary activity.
    h. Professional liability claims history
    i. Professional liability insurance valid and current
    j. Professional and Practice Services, which includes, but limited to the request of the following items (Please refer to Standard Operational Procedure (SOP) "CCS-CHDP-SPSP":
        1. Child Health and Disability Prevention Program (CHDP)
        2. California Children Services (CCS)
        3. Comprehensive Perinatal Services Program (CPSP)
        4. Other

B. Current valid California License to Practice his/her Profession

1. Must hold and maintain a current and valid California License to practice his/her Profession within the constraints of Section 2113 of the California Business and Professions Code. However, the Credentialing Committee or Medical Director may consider practitioners with license restrictions, so long as the restrictions and limitations on their scope of practice will not hinder the practitioner from complying with his/her contractual and professional obligations. At any time if the Primary Care Practitioner/Provider allows their license to expire/lapse it will be an immediate suspend the day of expiration and followed by a termination of contract the following day with transferring of membership notification sent to all Health Plans. **Note:** If the term and transfer is submitted to all Health Plans there will not be a reversal of submission.

2. A photocopy of the current unrestricted California License to Practice his/her Profession must be submitted with the completed reapplication and maintained in the provider's file.

3. The Credentialing Staff will perform primary source verification with the Medical Board of California or appropriate licensing board through internet access or by phone.

4. If the primary source verification indicates any investigation, limitations on scope of practice, restrictions on licensure, sanctions or other action, the information will be requested from the appropriate licensing board in writing.

C. Current clinical privileges in good standing in a Group approved hospital within the service area in the specialty that the provider is contracted for.

1. If the provider has no admitting privileges, a statement confirming coverage for any inpatient work will be included in the file and reasons for the exception documented. Arrangements for the admission and treatment of hospital patients by an approved provider must be established in a written agreement with the covering provider.

2. Exceptions may be granted if the provider's specialty does not typically require admitting privileges (e.g. Allergy, Dermatology, Pathology, Radiology, Optometrists or Chiropractors). However, if they indicate on their recredentialing application that they have hospital privileges, the privileges will be verified during the recredentialing process.

3. A letter is sent to the hospital(s) that the provider identifies in his application, along with a signed, dated Credentials Authorization and Release Form.

D. Current unrestricted DEA Certificate

1. All providers, except non-prescribing providers, must have a valid DEA certificate with a California address. If they do not have a California address on their DEA, then document who will prescribe for the practitioner until they have their California DEA. A photocopy of the DEA Certificate which clearly shows the number and expiration date must be submitted with the completed recredentialing application. (Chiropractors and Dentists are excluded)

2. The Credentialing staff will verify the DEA within 180 calendar days of the QM/Credentialing Committee decision by accessing the DEA website at https://www.deadiversion.usdoj.gov/webforms/dupeCertLogin.jsp.

E. Verification of Board Certification, if applicable

1. Board certification for MD's must be awarded by the American Board of Medical Specialties. Primary source verification is done via the internet by accessing ABMS at www.boardcertifieddocs.com. The data on this site is stored in and extracted from the database used to compose The ***Official*** ABMS Directory of Board Certified Medical Specialists.

2. Board certification for DO's must be awarded by the American Osteopathic Association. Primary source verification is done via the internet by accessing The Official Osteopathic Physician Profile Report at www.doprofiles.org.

3. Board certification for DPM's must be awarded by the American Podiatric Medical Association. Primary source verification is done via the internet by accessing www.abfas.org for the American Board of Foot and Ankle Surgery (ABFAS) or www.abpmed.org for the American Board of Podiatric Medicine (ABPM).

4. Board certification for DMD's must be awarded by the American Board of Oral Maxillofacial Surgery. Primary source verification is done via www.aboms.org.

F. Current certificate of malpractice insurance

1. Practitioners must maintain one (1) million dollars per case and three (3) million dollars aggregate minimum professional liability insurance coverage in the specialty that the provider is contracted for.

2. When the certificate of malpractice insurance is received, the Credentialing Staff sends a letter to the insurance carrier requesting verification of the policy to include policy number, limits of coverage, specialty and expiration date.

3. If the malpractice carrier lists any malpractice cases that the provider has not already explained in his/her application, then the Credentialing Staff writes to the provider and asks for his/her explanation with details of the case.

4. In cases of an urgent/rush fast track practitioner that needs to be processed quickly a current copy of the malpractice certificate is acceptable if it includes policy number, limits of coverage, specialty and expiration date

G. Provider must submit a history of all professional liability claims.

1. If the provider noted on his/her application that he/she has had any malpractice cases, he/she must submit a professional liability action explanation which must disclose date(s) and detail(s) of the incident(s) leading to the suit(s) or settlement(s); date(s) of suit(s) or settlement(s); name of professional liability insurer involved; applicants role in the incident(s); current status in any suit(s) or other legal action (primary, co-defendant, other); subsequent events, to include patient outcome; amount reserved by the insurance carrier for each claim or amount paid as an out-of-court settlement or amount of jury/court award.

H. Primary source verification with the National Practitioner Data Bank to identify any sanctions from Medicare/Medicaid, termination of privileges or malpractice suits.

1. The Credentialing Staff will query the NPDB via the internet at www.npdb-hipdb.hrsa.com.

   a. When the query is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.
   b. The results of the search are placed in the provider's credentialing file.

I. Primary source verification of State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice (i.e., identify any history of license actions including denials, revocations, terminations, suspension, restriction, reductions, limitations on practice, sanctions, probations and non-renewals. Any history of being charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded or have voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on the eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, any federal program or disclosure by application attestation questions)

2. Federation of State Medical Boards (FSMB) to identify any sanctions from other states for MD's and DO's.

    a. The Credentialing Staff will query and review the FSMB at initial credentialing and recredentialing cycles via the internet at www.fsmb.org
    b. When the query is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.
    c. The results of the search are placed in the provider's credentialing file.

3. Federation of Chiropractic Licensing Boards' Chiropractic Information Network/Board Action DataBank for Chiropractors.

    a. The Credentialing staff sends a written request to the board requesting information on any disciplinary activity for the applicant.

    b. When the verification is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.
    c. The results of the search are placed in the provider's credentialing file.

4. State Board of Dental Examiners for Dentists.

    a. The Credentialing staff sends a written request to the board requesting information on any disciplinary activity for the applicant.
    b. When the verification is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.
    c. The results of the search are placed in the provider's credentialing file.

5. Federation of Podiatric Medical Boards for Podiatrists.

    a. The Credentialing staff sends a written request to the board requesting information on any disciplinary activity for the applicant.
    b. When the verification is received and contains a disciplinary action, it is compared with information received in the provider's application. If there is a discrepancy, the provider is asked for clarification.
    c. The results of the search are placed in the provider's credentialing file.

6. Individual State licensing board for each type of licensure.

7. Medi-Cal Suspended and Ineligible Provider List

    a. The Credentialing Staff will query and review the Medi-Cal Suspended and Ineligible Provider List at initial credentialing and recredentialing cycles via the website http://www.medi-cal.ca.gov/references.asp
    b. The results of the search are documented on the form entitled "Medi-Cal Suspended and Ineligible Report" and placed in the provider's credentialing file.
    c. The IPA will not contract with a provider who is suspended or ineligible.

8. The Department of Health and Human Services, Office of Inspector General (OIG) Exclusions & Reinstatement Reports

    a. The Credentialing Staff will query and review the OIG Exclusion and Reinstatement Database at initial credentialing and recredentialing cycles via the website www.oig.hhs.gov.
    b. If a provider is matched, a written request for the provider sanction information is sent to Office of Investigation; Health Care Administrative Sanctions; Room N2-01-25; 7500 Security Blvd., Baltimore, MD 21244-1850.
    c. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
    d. The IPA will not contract with a provider who has been excluded/sanctioned from government programs.

9. Medicare Opt Out Report – for the Medicare line of business -Opt-Out Affidavits Database@ data.cms.gov:

c. The Credentialing Staff will access and review the Medicare Opt Out Report at initial credentialing and recredentialing cycles via the website https://data,cms,gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z
    a. The results of the search are documented on the form entitled "Medicare Opt Out Report Findings" and placed in the provider's credentialing file.
    b. The IPA will not contract with a provider who has Opted Out of Medicare.

10. The Excluded Parties List System-EPLS (System for Award Management-SAM) Reports

    a. The Credentialing Staff will query and review the SAM (System for Award Management) Database at initial credentialing and recredentialing cycles via the website www.sam.gov
    b. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
    c. The IPA will not contract with a provider who has been debarred from participating in government contracts.

11 The NPI and Medi-Cal Number

a. The Credentialing Staff will query and review the NPI and Medi-Cal Number Database at initial credentialing and recredentialing cycles via the website https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a

b. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.

c. If a practitioner(s) is/are Not Medi-Cal enrolled the credentialing coordinator will notify the Provider Services representative to notify and provide the practitioner with the website to begin the provider enrollment process directly through DHCS or through its contracted health plan representative. This will include all provider types delineated by DHCS. http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

d. The Credentialing Staff will not complete the recredentialing process until the Practitioner(s) have been enrolled. This is for the Medi-Cal contract.

12. CMS Preclusion List

a. The Credentialing Staff will query the CMS Preclusion List database via the website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html currently, the CMS Preclusion List is being submitted to the IPA groups by their contracted health plan.
b. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
c. The IPA will terminate a provider who is on the CMS Preclusion List.

I. A Provider Quality Profile is maintained in each provider's file and contains information from the following sources:

1. Review of data from member complaints,
2. Results of quality reviews,
3. Utilization reviews,
4. Member satisfaction surveys,
5. Medical record reviews, and
6. Results of site visits

J. A provider office on-site visit is required on all Primary Care Providers. The visit will include a review of medical records and a structured physical site review. If the provider has had a site visit performed by any of the contracted health plans utilizing the DHS Facility Site and Medical Record tool, a copy of the results of this visit will satisfy this criterion. Refer to CR 3 Provider Facility Site Review.

1. A PCP is defined as a General Practitioner, Family Practitioner, Internist, Pediatrician, or an OB/Gyn who requests PCP status, who by contract agree to accept responsibility for primary care services.

K. The Medical Director reviews all credentialing files, approving those that meet minimum eligibility requirements (clean files). All files approved by the Medical Director are reflected in the QM/Credentialing Minutes as having been approved without objection on the date of the Medical Director's signature.

L. The following specific exceptions require review & sign-off by the Credentialing Committee:

1. Three (3) malpractice cases over $30,000 within five (5) consecutive years; or
2. One (1) malpractice case over $100,000 within five (5) consecutive years; or
3. Malpractice cases that are repetitive because of type of specific practices.
4. Past, current and pending Medical Board Actions; Business and Professions Code 805 violations
5. Committed a felony or other act involving moral turpitude, dishonesty, fraud, deceit or misrepresentation or is under investigation with respect to such conduct.
6. Four (4) potential Quality Indicators (PQI's) within two (2) years; and/or
7. One (1) Quality Indicator (QI) within two (2) years.

8. Medical Record Review score of less than 80% within two (2) years.
9. Non-compliance with a corrective action plan.
10. Any provider that has an issue with over or underutilization for their specialty as determined by Utilization Management.

M. Practitioner's Rights and Responsibilities

1. The provider is notified, in writing, by the Credentialing staff when presented with a recredentialing application, that they have a right to review non-privileged information obtained to evaluate their recredentialing application; a right to be informed, upon request, of the status of their recredentialing application; and that they have the right to correct erroneous information submitted by another party, provided the information is not peer-review protected. This includes information obtained from outside sources such as liability carriers, Medical Boards, NPDB. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure. Requests are to be in writing via fax or letter to the Director of Credentialing of the IPA/Medical Group and will be responded to within three (3) days to arrange a date and time for such review.

2. Providers are notified, in writing, by the Credentialing staff when information obtained by primary sources varies substantially from information provided on the provider's application. Providers will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if the information obtained is not intended for verification of credentialing elements or is protected from disclosure by law. Providers have the right to correct erroneous information by submitting a detailed explanation in writing to the Director of Credentialing of the IPA/Medical Group within fifteen (15) days of notification of discrepancy.

3. Upon receipt of explanation from provider, Credentialing staff will re-verify primary source information under consideration. If primary source information has changed, an immediate correction will be made to credentialing file. If primary source information remains inconsistent, provider is notified in writing via fax or letter requesting proof of correction by primary source within ten (10) working days. A second re-verification of primary source information will be performed by Credentialing staff. If primary source information remains inconsistent, it will be reviewed at time of presentation to the QM/Credentialing Committee.

N. The completed file, including all credentialing information, is submitted to the QM/Credentialing Committee within one-hundred-and-eighty (180) days of the provider's attestation and dates of primary source verifications for review.

1. If the provider's recredentialing file is approved, the Credentialing Department notifies the provider in writing within sixty (60) calendar days.
2. If the provider's recredentialing file is denied, please refer to Policy CR 5 Reduction, Suspension or Termination of Provider Status.

O. QI/Credentialing Committee – The QI/Credentialing Committee is part of the Quality Improvement Committee. Meetings will convene on a monthly basis (minimum quarterly). Members of the committee are rotated annually to assure broad representation but serve staggered two (2) year terms to ensure continuity. The committee has access to board certified specialty physicians who may be asked to join the committee on an ad hoc basis, if needed. The chairperson or designee will facilitate each meeting.

<u>Membership – (voting rights):</u>
QM Chairperson
Medical Director
Two (2) Primary Care Physicians

One (1) Specialty Care Physician	Medical Management Credentialing
<u>Membership – (nonvoting rights):</u> President	Member Services Contracting/Provider Services

1. The number of members required for a quorum shall be determined to be a minimum of three (3) physicians. Consultation with specialists is an option open to the QM/Credentialing Committee on an as needed basis.

2. The Board of Directors of the IPA/Medical Group has delegated to the QM/Credentialing Committee the authority to review credentialing policies and procedures and to recommend revisions, additions and/or deletions deemed necessary; to perform peer review functions in concert with credentialing; to review and evaluate the qualifications of each applicant and practitioner; and to make credentialing decisions to approve or to deny applicants.

3. A consistent format of minutes will be reviewed and approved by the QM/Credentialing Committee. Recorded separate from other committee agendas, the minutes will be maintained in a binder organized by the most recent date. Minutes of previous meetings will be made available for health plans that request a review. Minutes and other confidential documents may not be removed from the QM/Credentialing office, nor reproduced in any manner and will be kept in a locked area.

P. On a quarterly basis, the Credentialing Committee prepares a report that is presented to the Board of Directors of all providers that have been approved or denied.

NON-DISCRIMINATORY CREDENTIALING:

The IPA monitors and prevents discriminatory credentialing through the following processes:

1. Tracking and trending of reasons for denial and/or terminations.
2. Semi-annual audit of files in process for greater than six (6) months to determine compliance with practitioner contract criteria.
3. The presence of a nondiscrimination statement on the "Provider Panel Confidentiality Statement" to be signed by UM/QM/Credentialing Committee members.
4. Documents and/or information submitted to the QM/Credentialing Committee for approval, denial or termination do not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, or patient type of procedures performed or payor sources.

FORMS:

California Participating Physicians Reapplication

REFERENCES:

HSMSO CR 3 Provider Facility Site Reviews
NCQA MCO Standards and Guidelines – Credentialing and Recredentialing
CMS Guidelines

SUBJECT: Practitioner Office Site Quality (Medicare & Commercial) **Policy #:** CR 3
DEPARTMENT: Quality Management/Credentialing

Effective Date: January 2009
Revised: January 2010; January 2011; January 2012; January 2013; January 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020; January 2021, January 2023

SCOPE:

This policy applies to the Medicare and Commercial lines of business.

PURPOSE

To define the requirements and procedures for Provider Office Survey Site Reviews conducted by IPAs to ensure that all sites have sufficient capacity to provide appropriate primary health care services, carry out processes that support continuity and coordination of care, maintain patient safety standards and practices.

POLICY

Site reviews for counties that do not delegate this process to its IPAs, will be performed by the Health Plan or its designee.

Individual Health Plans shall have the ultimate oversight and monitoring responsibility for all delegated Facility Site Review functions performed by their IPAs within their jurisdiction of responsibility.

The criteria for the FSR should include, but are not limited to, accessibility equipment, (i.e. scales, and exam table and equipment for treatment and diagnosis) safety, physical accessibility (i.e. handicapped accessibility), physical appearance (i.e. cleanliness and orderliness, well-lit waiting rooms, posted office hours), adequacy of waiting and examining room space (i.e. adequate waiting room space, adequate number of examining rooms per practitioner), adequacy of equipment (i.e. current fire extinguisher, refrigerator housing specimens and medications is correct temperature and separate from food and personal items, sterilization equipment, current certifications for imaging equipment), adequacy of the medical records keeping and filing, including maintenance of confidentiality, availability of appointments, storage of medications and narcotics and emergency procedures

The criteria for the MRR should include, but not limited to, secure/confidential filing system, legible file markers, records can be easily located.

IPAs shall provide ongoing oversight and monitoring of sites between reviews through data submission and monitoring of member complaints/grievances. Sites receiving three (3) or more complaints in a six (6) month period or in alignment with health plan thresholds will require a site review within sixty (60) calendar days. When appropriate, complaints will be forwarded to the applicable health plan upon receipt.

IPAs shall be responsible for the monitoring and review activities of sites and conduct, or contract with a vendor to conduct, subsequent periodic Provider Office Survey Site Reviews of sites to determine compliance with applicable federal, state, and local laws and regulations, or more frequently, if required by local collaborative decision, or as a health plan or the IPA determines necessary based on monitoring, evaluation, potential quality of care concerns, or Corrective Action Plan (CAP) follow-up issues.

IPAs, or their contracted vendor, shall utilize approved and qualified staff to conduct Provider Office Survey Site Reviews in accordance with the requirements of this policy.

IPAs shall cooperate with health plans in the oversight process. IPAs shall monitor and conduct oversight audits of site reviews performed by a contracted vendor.

The IPA site review audit processes described in this policy shall be confidential and protected from disclosure in accordance with applicable law.

IPAs shall ensure the correction of all deficiencies identified during Provider Office Survey Site Reviews in accordance with the requirements of this policy. Notwithstanding the corrective action time requirements set forth in this policy, an IPA shall not allow a site with major or serious uncorrected deficiencies to continue providing care to Members until all such deficiencies have been corrected.

PROCEDURE

IPAs shall use the ICE California Shared Commercial & MediCare Provider Office Survey & Corrective Action Plan to conduct Provider Office Survey Site Reviews.

IPA shall conduct a Provider Office Survey Site Review if required by local collaborative decision, or as a health plan or the IPA determines necessary based on monitoring, evaluation, potential quality of care concerns, or Corrective Action Plan (CAP) follow-up issues. Sites receiving three (3) or more complaints in a six (6) month period or in alignment with health plan thresholds, will require a site review within sixty (60) calendar days. A site visit resulting from a complaint must include an evaluation of all office site criteria: appointment, the site visit must be performed within (60) calendar days of the complaint threshold being met. Reviewer must see evidence of site visit being performed if complaint threshold is met.

All sites are required to pass Provider Office Survey Site Reviews with a minimum passing score of eighty percent (80%).

Points and Scoring:

Full Pass: Ninety
Conditional Pass: Eighty to Eighty-nine percent (80-89%); or
Full Pass: Ninety percent (90%);
Not Pass: below eighty percent (80%).

An IPA shall require that providers implement a Corrective Action Plan (CAP) based on the site review scores.

1. An IPA shall require sites with a conditional pass score to submit a CAP to correct/address one hundred percent (100%) of the cited deficiencies. CAP notification and completion shall occur according to the following:

    a. At the time of the review, reviewers shall notify providers of:

        i. Non-passing scores;
        ii. Other deficiencies determined by the reviewer or IPA to require immediate correction; and
        iii. CAP requirements for all deficiencies.

    b. Within ten (10) working days after the date of the survey:

        i. IPAs shall provide a review of the findings report and a formal written request for corrections of all other deficiencies to the provider.

    c. Providers shall submit a written CAP for all other deficiencies as follows:

        i. Within forty-five (45) calendar days after the review date (or the date a CAP is received if not given at the time of the review);
        ii. Upon receipt of a provider's CAP, the IPA shall have forty-five (45) calendar days to review the provider's CAP and notify the provider of any further deficiencies; and
        iii. If deficiencies are noted, providers shall have an additional thirty (30) calendar days to complete these deficiencies.

    d. Within one hundred and twenty (120) calendar days from the date of the site review:

        i. Providers shall complete all corrective actions; and
        ii. The IPA shall provide education support and technical assistance as needed, re-evaluate/verify corrections, and close the CAP.

    e. After passage of one hundred and twenty (120) calendar days after the date of the site review, the IPA shall:

        i. Report non-compliance to its own Quality Improvement Committee; and
        ii. Follow the guidelines delineated below.

    f. Contracted sites with non-passing scores

        i. Providers shall be notified of the review score, all cited deficiencies, and CAP requirements at the time of the non-passed review.

ii. IPAs shall have the right to remove any provider with a non-passing score from the IPA's provider network.
iii. Any site with a non-passing score who is allowed to remain in the IPA shall correct deficiencies within the CAP timelines established in this policy. The IPA shall verify correction of the deficiencies within the CAP timelines.
iv. New Members shall not be assigned to a site that scores below eighty percent (80%) on a subsequent Provider Office Survey Site Review until corrections are verified and the CAP is closed.

Non-compliant Providers

1. Providers who do not correct review deficiencies within the established CAP timelines shall not be assigned new Members until corrections are verified and the CAP is closed.
2. IPA shall obtain approval from a health plan for any site that has delayed its CAP submittal beyond sixty (60) calendar days after the date of the written CAP request.
3. A provider may request a definitive and time-specific extension period not to exceed ninety (90) calendar days after survey findings and CAP notification.
4. If a provider does not comply with a CAP within the established timelines, the IPA shall present the issue to its QM and/or Peer Review committee for further action. The health plan may request that members be re-assigned.
5. IPAs shall provide Members with thirty (30) day notice that a non-compliant provider is being removed from the IPA.

Monitoring

1. The IPA will evaluate the effectiveness of the CAP at least every six (6) months until the site(s) with deficiencies meet the thresholds. Once the CAP is accepted, the results and findings will be included in the Credentialing/recredentialing file and reported to the QM/Credentialing Committee.
2. IPAs shall systematically monitor provider sites for deficiencies subsequent to the initial site visit, at least every six (6) months.
3. Monitoring methods may include site visits but shall also include other methodologies such as information gathered through established internal IPA processes (i.e. quarterly review of member grievances), provider and program specific reports from external sources, or Focused Reviews. If a provider has received 3 or more complaints in a 6 month period, a site visit will be required within sixty (60) calendar days. When appropriate, complaints will be forwarded to applicable health plan upon receipt.
4. Monitoring sites between reviews shall include the use of both internal (e.g. quality improvement) systems and external (e.g. public health) sources of information.
5. When problems are identified through monitoring processes, IPA shall determine the appropriate course of action to assure that problems are fully investigated and corrected in a timely manner. The IPA will evaluate the site at least every six (6) months until the site with deficiencies meet the thresholds.
6. Follow-up visits will be conducted for a previously deficient office if the practice site meets the complaint threshold subsequent to correcting the deficiencies.

Provider Appeal Process

1. Providers removed from an IPA shall have the right to file a complaint with the IPA according to the Provider Grievance Process.
2. If an IPA accepts verified evidence of correction and the decision is reversed, the IPA shall repeat the Provider Office Survey Site Review or accept the current Provider Office Survey Site Review and CAP as completed. A re-survey shall be completed within twelve (12) months. If the IPA does not reverse the decision, the provider may re-apply through application processes established by the IPA.

FORMS:

California Shared Commercial & MediCare Provider Office Survey & Corrective Action Plan

REFERENCES:

None

SUBJECT: Denial of Participation **Policy #:** CR 4
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 1, 2006
Revised: February 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; January 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020, **January 2021 January 2023**

PURPOSE:

To establish a consistent policy for denying provider participation in the network prior to contracting.

POLICY:

Applicants to the IPA network who are determined by Contracting, Quality Management or Credentialing to not meet criteria, shall be denied participation in accordance with this procedure. Grounds for denial of application as a network provider include:

Contracting/Administrative:

1. Network adequacy; full scope of type/specialty provider within panel of providers.
2. Restricted member practice

Credentialing/Administrative:

1. Does not meet credentialing requirements as outlined in Credentialing Policy & Procedures.

2. Refusal to comply with submission of information required during the credentialing verification process.

3. Refusal to sign a required release form.

Quality Management:

1. Quality of care issues[1]

PROCEDURE:

Prior to, or during, the initial credentialing process, any of the issues above may be identified.

The provider's application is submitted to the QM/Credentialing Committee for review and action.

If network participation is denied, due to any reason as stated above, the applicant will receive written notice (sent by certified mail) within sixty (60) days that he or she does not meet the IPA's basic criteria.

If the criteria is related to a quality of care issue, the written notice will include his or her right to request a hearing in the manner specified in the Fair Hearing Plan[1].

[1] Requires notice of Fair Hearing Plan

If no provider response is received within ten (10) days from the date of the determination letter, the matter is considered closed.

A copy of the letter is maintained in the contracting department.

For Administrative terminations, providers may be eligible to reapply immediately upon providing required information.

For Quality of Care terminations, a provider may be eligible to reapply one (1) year from termination date after review and determination by QM/Credentialing Committee.

FORMS:

None

REFERENCES:

HSMSO CR 1 Credentialing Policy & Procedures – Physicians
HSMSO CR 10 Credentialing / Recredentialing Policy & Procedures – Mid-Level Practitioners
NCQA MCO Standards & Guidelines – Credentialing & Recredentialing
CMS Guidelines

SUBJECT: Reduction, Suspension or Termination of Provider Status **Policy #:** CR 5
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 1, 2006
Revised: February 2007; March 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; October 2013; January 2014; September 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020, January 2021, January 2023

SCOPE:

This policy applies to all contracted providers participating on the provider panel. This includes the following:

Medical Doctors - M.D.
Doctors of Osteopath - D.O.
Doctors of Dental Medicine, Surgery - D.D.S. & D.M.D. (excluding dentists who provide only primary dental care)
Doctors of Podiatry - D.P.M.
Chiropractors - D.C.
Optometrists – O.D.
Clinical Psychologists – Ph.D.
Non-Physician Behavioral Health – L.M.F.T., M.F.C.C., L.C.S.W.
Audiology – Au.D. and Hearing Aid Dispensers – H.A.
Speech-Language Therapists – S.L.P.
Occupational Therapists – O.T.
Physical Therapists – P.T.
Physician Assistants -P.A.
Nurse Practitioners -N.P.
Clinical Nurse Specialists - C.N.S.
Certified Nurse Mid-Wives - C.N.M.

Such other practitioner or healthcare delivery organization (HDO) authorized by law to deliver health care services in the outpatient independent practice settings.

PURPOSE:

The purpose of this policy is to provide a fair and efficient means to identify, investigate and resolve problems arising from the conduct of any contracted provider that may adversely affect patient care or the operation of the IPA or to address issues that indicate that a contracted provider does not meet the IPA's qualifications.

POLICY:

A provider's status may be reduced, suspended or terminated for any lawful reason, including but not limited to a lapse in basic qualifications such as licensure, insurance, or required medical staff membership or privileges at a specified hospital/healthcare facility; exclusion from participating in

government health programs, i.e. the Medicare Program, Medi-Cal program, etc.; a determination that the provider cannot be relied upon to deliver the quality or efficiency of patient care desired; a determination that the provider cannot be relied upon to follow clinical or business guidelines or directives; or a change in business needs.

PROCEDURE:

A. Initiation

Whenever the quality of care, competence or professional conduct of any contracted provider is considered to be detrimental to the goals and obligations of the IPA, or in violation of the group's Physician Agreement, policies and procedures, or lower than the professional standards, performance or qualifications for the group's contracted providers, or when the IPA has been directed to take action by a contracted health plan, the Medical Director, any member of the QI Committee, any member of the QI/Credentialing Committee, or the Board of Directors of the IPA may request corrective action against the contracted provider. In addition, any committee may request a review of such contracted provider's performance and/or adherence to all applicable policies and procedures. All requests for corrective action will be submitted to the QI/Credentialing Committee Chairman and will set forth the specific issues resulting in the request.

B. Investigation

The QI/Credentialing Committee will commence an investigation into the matter, either on its own or through an ad hoc committee appointed for that purpose. The Committee's review discussions and deliberations shall be the basis of its decision-making process. These discussions shall be undertaken with appropriate objectivity and shall involve Committee review of verified data, documents, and other relevant materials.

C. IPA Action

After duly considering the information in light of the IPA's participation/credentialing criteria, a quorum of the QI/Credentialing Committee shall agree, by majority vote to:

1. Deny or terminate the contracted provider's status;
2. Reduce contracted provider's participation in the IPA provider network which may include, but is not limited to, discontinuing assignment of new patients to the contracted provider;
3. Suspend contracted provider's participation in the IPA provider network and assigning the contracted provider's members to another contracted provider;
4. Reprimand or other action deemed appropriate by the QI/Credentialing Committee

If continued network participation is denied or terminated, the applicant will receive written notice (sent by certified mail) within sixty (60) days.

If the physician is denied participation or terminated for no cause, written notice will be sent to the Health Plans sixty (60) days in advance to be effective sixty (60) days from the date of receipt by the IPA.

For Administrative terminations, providers may be eligible to reapply immediately upon providing required information. If the provider requests to be reinstated within thirty (30) days of termination, the provider would not have to go through the initial credentialing process. All breaks in service of thirty (30) days or more shall require going through the initial credentialing process.

D. Summary or Immediate Reduction or Suspension

In instances where there may be an imminent danger to the health of any individual, the Chairman of the QI/Credentialing Committee with the Medical Director/Executive Director may summarily reduce or suspend the provider's privilege to provide patient care services, effective immediately upon notice to the provider. Such notice will be in writing, either personally delivered or mailed certified with return receipt requested. The notice shall be given to the Board of Directors for ratification and contracted provider's members shall be assigned to another contracted provider. If a health plan, Department of Managed Health Care (DMHC), Department of Health Services (DHS), or Office of Inspector General (OIG) instructs the IPA to reduce or suspend a contracted provider retroactively, the IPA must under contract follow the health plan's direction and notify all key internal departments..

E. Fair Hearing

In accordance with CR 6 Fair Hearing Plan, a contracted provider shall be entitled to a hearing only when, on the basis of a medical disciplinary cause or reason, the QI/Credentialing Committee has:

1. Denied or terminated his/her participation in the IPA provider network;

2. Suspended or reduced contracted provider's participation in the IPA network for a cumulative total of thirty (30) calendar days or more in any twelve (12) month period; or

3. Summarily suspended contracted provider's participation in IPA network for more than fourteen (14) consecutive calendar days.

F. Automatic Reduction or Suspension

1. License

Whenever a provider's license or other legal credential authorizing practice in this state is restricted or suspended by the applicable licensing and certifying agency, or has been allowed to expire, his or her authority to provide care to IPA members will be automatically restricted effective upon receipt by IPA of notice thereof. In the event a temporary restraining order or other type of court order or legal restriction is placed on a provider by a court, his/her authority to provide care to IPA patients will be automatically restricted or suspended consistent with the terms of the court order until resolution of the matter.

2. Drug Enforcement Agency

A temporary suspension of a provider's authority to prescribe controlled substances

or other medications to IPA members will be immediately imposed by the IPA upon the receipt of notice that such provider's right or license to prescribe or obtain controlled substances or medications has been suspended or revoked by the governmental agency and will be effective until the governmental agency reinstates the provider's right or license in question. If a provider's right or license to prescribe or obtain controlled substances or medication is subject to an order of probation, the provider's authority to prescribe controlled substances or other medications to IPA members will automatically become subject to the terms of the probation effective upon and for at least the term of the probation.

3. Malpractice Insurance

For failure to maintain the required amount of professional liability insurance, or its equivalent and to provide evidence of such coverage as required under the Credentialing criteria, a contracted provider's authority to provide care to IPA members, after written warning of delinquency, will be automatically suspended and will remain so suspended until the contracted provider shows evidence to the QI/Credentialing Committee that he or she has secured professional liability coverage in the amount required. A contracted provider who is suspended may not provide any care to IPA members. For the period of the suspension, IPA will temporarily refer all members enrolled with the contracted provider to another IPA contracted provider.

Failure to provide evidence of professional liability coverage in the amount required within three (3) months after the date of the automatic suspension became effective will be deemed a voluntary resignation by IPA.

Any contracted provider automatically suspended or restricted as described above, shall not, by the passage of time or the curing of the event which gave rise to automatic suspension or restriction, be automatically reinstated to his/her status. Instead, in order to regain his/her status, the provider shall be required to file a new application with the IPA.

G. Automatic Termination

1. Conviction of a Felony

After a conviction of a felony of a contracted provider in any court of the United States, either federal or state, the contracted provider's status with IPA is automatically terminated.

2. Exclusion from Government Health Programs

After being excluded from participating in government health programs, i.e., the Medicare program, Medi-Cal program, Healthy Families program, etc., the contracted provider's status with the IPA is automatically terminated.

H. Confidentiality

All Quality Improvement, Credentialing and Peer Review records and proceedings shall be confidential as contemplated by Section 1157 of the California Evidence Code.

I. Reporting

The IPA shall comply with the reporting requirements of the California Business and Professions Code and the Federal Healthcare Quality Improvement Act by reporting serious quality deficiencies to the appropriate authority or monitoring organization. The provider will be notified of the report and its contents.

FORMS:

None

REFERENCES:

HSMSO CR 2 Recredentialing Policy & Procedure – Physicians
HSMSO CR 6 Fair Hearing Plan
HSMSO CR 12 Monitoring and Sanctioning

SUBJECT: Fair Hearing Plan **Policy #:** CR 6
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 1, 2006
Revised: February 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; January 2014; September 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020 ; January 2021, January 2023

PURPOSE:
To comply with the requirement to provide practitioners with a well-defined appeal process and access to a fair hearing, if requested and applicable.

POLICY:

Contracted providers or new applicants whose participation in the IPA panel has been denied, reduced, suspended or terminated for quality of care/medical disciplinary causes or reasons (MDCR) shall be provided notice and opportunity for a hearing in accordance with this policy. "Medical disciplinary cause or reason" means that aspect of a contracted provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care. Such conduct includes that which affects, or could adversely affect, the health or welfare of a patient.

This policy applies to all new applicants and contracted providers participating on the provider panel. This includes the following:

Medical Doctors - M.D.
Doctors of Osteopath - D.O.
Doctors of Dental Medicine, Surgery - D.D.S. & D.M.D. (excluding dentists who provide only primary dental care)
Doctors of Podiatry - D.P.M.
Chiropractors - D.C.
Optometrists – O.D.
Clinical Psychologists – Ph.D.
Non-Physician Behavioral Health – L.M.F.T., M.F.C.C., L.C.S.W.
Audiology – Au.D. and Hearing Aid Dispensers – H.A.
Speech-Language Therapists – S.L.P.
Occupational Therapists – O.T.
Physical Therapists – P.T.
Physician Assistants -P.A.
Nurse Practitioners -N.P.
Clinical Nurse Specialists - C.N.S.
Certified Nurse Mid-Wives - C.N.M.

DEFINITIONS:

Medical disciplinary cause or reason (MDCR): That aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Practitioner or Provider: A participant who is permitted by law to provide patient care services without direction or supervision, within the scope of his or her license including, but not limited to, Doctors of Medicine (M.D.), Doctors of Osteopathy (D.O.), Doctors of Dental Surgery (D.D.S.) that are providing services under medical benefits and Doctors of Podiatric Medicine (D.P.M.).

GROUNDS FOR A HEARING

A contracted provider shall be entitled to a hearing if the QM/Credentialing Committee makes a recommendation to take one or more of the following actions against a contracted provider **based on a MDCR:**

1. Denial or Termination of practitioner's participation on the IPA provider panel

2. Suspension or Reduction of practitioner's participation on the IPA provider panel for a cumulative total of thirty (30) calendar days or more in any twelve (12) month period

3. Summarily Suspension of practitioner for more than fourteen (14) consecutive calendar days

4. Immediate Suspension or Restriction of practitioner's participation on the IPA provider panel where the failure to take such action may result in an imminent danger to the health of any individual.

PROCEDURE

A. Notice of Action or Proposed Action

1. Whenever there are grounds for a hearing as set forth in Policy CR 5 Reduction, Suspension or Termination of Provider Status, the affected provider shall be given a written notice from the QM/Credentialing Committee advising of the proposed action and a summary of the provider's appeal rights and process, including, but not limited to, the provider's right to request a formal hearing. This notification will include a copy of Policy CR6 Fair Hearing Plan.

   The notice will state:

   a. A brief description of the reasons for the action or proposed action

   b. That the action or proposed action, if implemented, shall be reported to the appropriate licensing board pursuant to the California Business and

Professions Code Section 805; to the National Practitioner Data Bank (NPBD) pursuant to the Health Care Quality Improvement Act (HCQIA) of 1986; or to such other state or federal agencies as may be required by law or warranted by the circumstances to protect the health and safety of patients

c. That the contracted provider has the right to file a written request for a hearing on the action or proposed action.

    1. The written request for a hearing must be received by the QM/Credentialing Committee no later than thirty (30) calendar days from the date of notice.

    2. If the contracted provider fails to request a hearing within the time and manner described herein, the contracted provider shall be deemed to have accepted the QM/?Credentialing Committee's decision and the action or proposed action will be FINAL AND EFFECTIVE IMMEDIATELY UPON EXPIRATION OF THE THIRTY (30) DAY TIME LIMIT provided by the notice.

d. That, if applicable, the contracted provider's participation is hereby suspended until:

    1. The thirty (30) day appeal period has lapsed with no appeal from the contracted provider and a notice of adoption of QM/Credentialing Committee's action has been sent, or

    2. The contracted provider has appealed the QM/Credentialing Committee's decision and the Hearing Committee has overturned the original decision.

e. The final proposed action, if applicable

The Notice shall be sent by first-class U.S. mail, postage prepaid, certified with return receipt requested, to the contracted provider's address listed with IPA.

B. Request for Hearing

The affected contracted provider shall have thirty (30) calendar days following the date of notice to request a hearing. The request for a hearing must be submitted in writing to the QM Committee Chairman or such officer that the Committee may designate to perform such function at IPA's principal business address.

Upon receiving a request for a hearing, the QM Committee Chairman shall schedule and arrange for a hearing. Unless the Committee and contracted provider agree otherwise in writing, the requested hearing shall be held no less than thirty (30) calendar days and no more than sixty (60) calendar days from the date that the contracted provider's request is received by the QM Committee.

C. Notice of Hearing

1. The QM Committee Chairman shall give the contracted provider written notice of the hearing. The notice of the hearing shall include the following:

    a. The time, date, and place of the hearing.

    b. The reasons for the proposed action, including the acts or omissions with which the contracted provider is charged.

    c. That the hearing will be held before a Hearing Committee appointed by IPA.

    d. That the contracted provider's right to a hearing will be forfeited if the contracted provider fails, without good cause, to appear at the hearing.

2. The notice shall be sent first-class U.S. mail, postage prepaid, certified with return receipt requested, to the contracted provider's address listed with IPA.

D. Hearing Committee

1. The QM Committee shall appoint a Hearing Committee consisting of at least three (3) contracted providers who will be peers of the affected provider, and an alternate contracted provider, with current contracted provider agreements with IPA. The majority of the members will have the requisite expertise to ensure a fair hearing. The alternate contracted provider will attend the entire hearing but will take part in the deliberations of the Hearing Committee only if a member of the Hearing Committee is not available to participate in such deliberations.

2. To be eligible to serve in this capacity, prospective panel members shall:

    a. not have prejudged the matter (i.e., shall be unbiased)

    b. not have actively participated in the formal consideration of the matter at any previous level (i.e., they shall not have acted as an accuser, investigator, fact finder or initial decision-maker in the same matter)

    c. not be in direct economic competition with the affected contracted provider, and shall not stand to gain direct financial benefit from the outcome.

    Whenever possible, at least one (1) member of the Hearing Committee should practice the same specialty as the affected contracted provider or knowledgeable with the adverse HDO issue.

E. Hearing Officer

1. The QM Committee Chair may appoint a Hearing Officer, preferably with experience in professional peer review proceedings, to preside at the hearing. If a Hearing Officer is appointed, that individual shall:

    a. not be biased for or against the practitioner

    b. gain no direct financial benefit from the outcome

    c. not act as a prosecuting officer or as an advocate of any party, and

    d. not be entitled to vote.

2. The Hearing Officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order and procedure for presenting evidence and testimony during the hearing, and shall have the authority and discretion, in accordance with this Fair Hearing Procedure, to grant continuances, to rule on disputed discovery requests and to decide when evidence may not be introduced.

    In the event no Hearing Office is appointed, the Hearing Panel will choose a Presiding Officer to assume the functions of the Hearing Officer as outlined herein, except that such Presiding Officer shall be entitled to vote.

F. Contracted Provider

1. The contracted provider shall have the right to a reasonable opportunity to question the Hearing Panel members and the Hearing Officer, if any, and the right to challenge the impartiality of any Panel member or Hearing Officer. Challenges to the impartiality of any Panel member shall be ruled on by the Hearing Officer (if one has been appointed).

G. Pre-Hearing Procedure

1. Discovery

    a. Rights of Inspection and Copying
    The affected provider may inspect and copy at his/her own expense any documentary information relevant to the charges that the QM/Credentialing Committee has in its possession or under its control. This committee or its representative may inspect and copy at the Medical Group's expense, any documentary information relevant to the charges that the affected provider has in his/her control. This right of inspection and copying does not create or imply an obligation to modify or create documents in order to satisfy a request for information. Requests for discovery must be met as soon as practicable. Failure to comply with reasonable discovery requests at least ten (10) working days prior to the hearing shall be good cause for a continuance of the hearing.

b. Limits on Discovery
The Hearing Officer, upon the request of either side, may impose safeguards including, but not necessarily limited to, the denial of a discovery request on any of the following grounds:

1. Whether the information sought may be introduced to support or defend charges.

2. Whether the information is "exculpatory" in that it would dispute or cast doubt upon the charges of "inculpatory" in that it would prove or help support the charges and/or recommendation.

3. The burden on the party of producing the requested information.

4. Other discovery requests the party has previously made.

2. Witness Lists
At least ten (10) working days prior to the hearing, the contracted provider and the QM/Credentialing Committee shall each furnish to the other a written list of the names and addresses of the individuals, who will give testimony or evidence in support of that party at the hearing. The witness list may be amended with a showing of good cause. A failure to comply with this requirement is good cause for the Hearing Officer to postpone the hearing or to limit the appearance of a witness.

H. Representation

Hearings are provided for the purpose of addressing issues of professional conduct or competence in healthcare. The provider may be represented by an attorney or person of his/her choice at the hearing. The IPA cannot have an attorney if the provider does not have attorney representation [Business & Professions Code 809.3(c)]

I. Failure to Appear at Hearing

Failure without good cause of the provider to appear and proceed at the hearing shall be deemed to constitute voluntary acceptance of the recommendation or action involved and it shall thereupon become the final action of the IPA. There shall be no right to appeal IPA's final action.

J. Postponements and Extensions

After a timely request for hearing has been received as described above, postponements and extensions of time beyond the times expressly permitted in the Fair Hearing Plan may be effected upon agreement of the parties or granted by the Hearing Officer on a showing of good cause and subject to the Hearing Officer's discretion to assure that the hearing proceeds and is completed in a reasonably expeditious manner.

K. Rights of the Parties at the Hearing

At the hearing, the affected contracted provider and the QM/Credentialing Committee shall have the following rights: to ask Hearing Committee members and the Hearing Officer questions which are directly related to determining whether they meet the qualifications set forth in this Fair Hearing Plan and to challenge the impartiality of such members or the Hearing Officer; to call, examine and cross-examine witnesses; to receive all information made available to the Hearing Committee; and to present and rebut any evidence determined to be relevant by the Hearing Officer. The contracted provider may be called by the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. Each party has the right to submit a written or verbal statement in support of his/her position at the close of the hearing. The Hearing Committee may request such a statement to be filed following the conclusion of the presentation of oral testimony.

L. Record of the Hearing

The Hearing Committee shall maintain a record of the hearing by using a certified shorthand reporter to record the hearing or by tape-recording the proceedings. The contracted provider shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. The Hearing Officer may, but is not required to, order that oral evidence shall be taken only on oath administered by a person designated by such body and entitled to notarize documents in this State or by affirmation under penalty of perjury to the Hearing Officer.

M. Rules of Evidence

Rules relating to the examination of witnesses and the presentation of evidence in courts of law shall not apply in any hearing conducted thereunder. Any relevant evidence, including hearsay, shall be admitted by the Hearing Officer if it is the sort of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs. However, the QM/Credentialing Committee's representative may object to the introduction of any evidence that was requested of an applicant but not provided during the credentialing process. Such objections shall be sustained by the Hearing Officer unless the applicant can prove that the information could not have been produced previously in the exercise of reasonable diligence.

N. Burden of Going Forward and Burden of Proof

In all cases, the QM/Credentialing Committee shall have the initial duty of presenting evidence to support the charge or recommended action. Thereafter, the burden differs depending upon whether the contracted provider is applying for participation in the IPA network or already has active provider status.

1. At any hearing involving denial or rejection of an application, the contracted provider has the burden of proving, by a preponderance of the evidence, that the committee's decision was not reasonable and warranted. The contracted provider must produce

information which allows for an adequate evaluation and resolution of any reasonable doubts concerning his or her current qualifications.

2. At any hearing involving a contracted provider who already participates with IPA, the QM/Credentialing Committee shall have the burden of proving by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

O. Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. The hearing shall be concluded within a reasonable time and the Hearing Officer may set guidelines for introduction of evidence to achieve a timely conclusion. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Hearing Committee shall thereupon, outside of the presence of the parties, conduct its deliberations and render a decision and accompanying report. Final adjournment shall not occur until the Hearing Committee has completed its deliberations.

P. Decision of the Hearing Committee

Within thirty (30) calendar days after final adjournment of the Hearing, the Hearing Committee shall render a decision. The decision of the Hearing Committee shall be based on the evidence produced at the Hearing and any written statements submitted to the Hearing Committee. The decision shall be accompanied by a written report that contains findings of fact and conclusions that articulate the connection between the evidence produced at the Hearing and the decision reached. The report shall include sufficient detail to enable the parties and the Board to determine the basis for the Hearing Committee's decision on each matter contained in the notice of charges. The decision and report shall be delivered to the parties by first-class U.S. mail, postage prepaid, certified with return receipt requested.

The decision of the Hearing Committee shall be by majority vote of the Committee, shall be final, and shall become the final action of IPA. There shall be no right to appeal the decision of the Hearing Committee. A contracted provider shall have a right to only one hearing as a result of any adverse recommendation or action based on a medical disciplinary cause or reason.

Q. Immediate Action by Peer Review Body Under Certain Circumstances

Notwithstanding anything in this Fair Hearing Procedure, the QM/Credentialing Committee may immediately suspend or restrict provider status of a contracted provider where the failure to take that action may result in an imminent danger to the health of any individual, provided that the contracted provider is subsequently provided with the notice and hearing rights set forth in this procedure.

CONFIDENTIALITY

All credentialing and peer review records and proceedings shall be confidential as defined by Section 1157 of the California Evidence Code.

REPORTING

The IPA shall comply with the reporting requirements of the California Business and Professions Code and the Federal Healthcare Quality Improvement Act regarding adverse credentialing and peer review actions.

PRIVILEGES AND IMMUNITIES

All activities conducted pursuant to this Fair Hearing Plan are in reliance on the privileges and immunities afforded by the HCQIA, the California Business and professions Code Section 809, and any other applicable state or federal laws and regulations. In the event of a conflict between this policy and California Business and professions Code Sections 805, 809-809.9 or the HCQIA, the provisions of the Code and/or the HCQIA shall prevail.

FORMS:

None

REFERENCE:

HSMSO CR 5 Reduction, Suspension or Termination of Provider Status
HSMSO CR 8 Reporting to MBC & NPDB
NCQA MCO Standards and Guidelines – Credentialing & Recredentialing

SUBJECT: Provider Quality Profile **Policy #:** CR7
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 1, 2006
Revised: February 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; January 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020, January 2023

PURPOSE:

To provide a mechanism for documenting, tracking and trending the findings of quality assessment and evaluation for use at the time of recredentialing and to facilitate the continuous improvement of the quality of care and services provided to members.

POLICY:

A provider profile will be maintained for each individual member of the provider panel.

The provider profile will include monitoring and evaluation results from Utilization Management, Member and Provider Services, Quality Management and other departments as deemed necessary in the reporting of provider issues that may effect the provider's continued participation with the group. This includes, but is not limited to, review of:

- Site Visits
- Medical Records review
- Results of any Potential Quality Issues
- Utilization Statistical Data
- Member and Provider Complaints and Grievances
- Access and Satisfaction Study

The profile is used at the time of recredentialing or at any other time deemed appropriate for evidence of the provider's knowledge, skill and judgment in member care and service.

Utilization statistical data will be used to identify over and under utilization activity by specialty provider, including behavioral health specialists. For the Healthy Family Program, providers who treat greater than fifty (50) members annually will be considered high volume behavioral health specialists.

PROCEDURE:

A. The original provider profile is initiated and maintained by the Credentialing staff.

B. When a provider is due for recredentialing, the Credentialing Department sends a Provider Profile form to the Quality Management, Utilization Management and Member/Provider Services Departments. This documentation is the objective evidence that an assessment of the provider's performance while working within the provider group is considered at the time of recredentialing.

C. When the form is returned to the Credentialing Department, it is incorporated into the provider's credentialing file to be reviewed by the Medical Director and QM/Credentialing Committee as part of the recredentialing decision making process.

FORMS:

Provider Quality Profile

REFERENCES:

None

SUBJECT: Reporting to MBC & NPDB **Policy #:** CR 8
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 1, 2006
Revised: February 2007; January 2008; January 2009; March 2009; January 2010; January 2011; January 2012; January 2013; January 2014; September 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020**; January 2021 , January 2023**

PURPOSE:

To comply with the Medical Board of California (MBC) and National Practitioner Data Bank (NPDB) reporting requirements for certain actions related to the Credentialing and Peer Review Process.

POLICY:

To provide procedures to comply with legal requirements to report certain actions taken by the IPA to the Medical Board of California and/or the National Practitioner Data Bank.

DEFINITIONS:

National Practitioner Data Bank: An alert or flagging system intended to facilitate a comprehensive review of health care practitioner's professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges.

The Medical Board of California: The State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Medical Disciplinary Cause or Reason: A medical disciplinary cause or reason is defined as an aspect of a practitioner's competence or professional conduct, which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

PROCEDURE:

805 and 805.01 REPORTS

Fair Hearing Rights - Except in the event of a summary suspension that exceeds fourteen (14) days in length or resignation or leave of absence as provided below, an 805 or 805.01 Report would never be filed until the practitioner has had the opportunity to either waive or exhaust his/her Fair Hearing rights in accordance with Policy CR 6 Fair Hearing Plan.

Required practitioner types for 805 and 805.01 reporting are: Medical Doctors (MD), Dentists (DDS), Osteopaths (DO), Podiatrists (DPM), Marriage Family Therapists (MFT), Licensed Clinical Social Workers (LCSW), Psychologists (PsyD, PhD) and Physician Assistants (PA).

Collectively, to be referred to as applicable practitioner types.

Actions Requiring 805 Reports - An 805 Report will be filed with the Medical Board of California whenever any of the following actions taken by IPA, the QM Committee or QM/Credentialing Committee involving applicable practitioner types become final:

- The practitioner's application for participation as a provider is denied or rejected for a medical or disciplinary cause or reason;
- The practitioner's provider status is non-renewed or restricted or terminated or revoked for a medical or disciplinary cause or reason;
- Restrictions are imposed or voluntarily accepted on the practitioner's authority to provide care to patients for a cumulative total of thirty (30) days or more for any twelve (12) month period for a medical disciplinary cause or reason;
- The practitioner resigns or takes a leave of absence from his/her provider status following notice of an impending investigation based on information indicating a medical disciplinary cause or reason; or
- A summary suspension remains in effect in excess of fourteen (14) days.

An 805 Report is filed with the Medical Board if the Practitioner takes any of the following actions listed below:

- Resignation or leave of absence by a Practitioner from IPA participation after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason;
- Withdrawal or abandonment of a Practitioner's application for IPA participation after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason; or
- Withdrawal or abandonment of a Practitioner's request for renewal of IPA participation after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason.

Actions Requiring 805.01 Reports - An 805.01 Report will be filed with the Medical Board of California whenever any of the following actions taken by IPA, the QM Committee or QM/Credentialing Committee involving applicable practitioner types become final:

- Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury that is dangerous or injurious to any person;
- The use of, prescribing for or self-administration (himself/herself) of any controlled substance, or use of any dangerous drug (as specified), or alcoholic beverages, that is dangerous or injurious to the licentiate (practitioner), any other person, public, or that the licentiate's (practitioner's) ability to practice safely is impaired by that use;
- Repeated acts of clearly excessive prescribing, furnishing, administering of controlled substances, repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior to examination of the patient and the medical reason for prescribing (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing).

- Sexual misconduct with one or more patients during a course of treatment or an examination.

Timeframe for filing an 805 or 805.01 Report

- **Resignation or Leave of Absence:** Within fifteen (15) days after the effective date of resignation or leave of absence.

- **Denial, Termination or Restriction:** Within fifteen (15) days after the conclusion of all of the proceedings under Policy CR 6 Fair Hearing Plan if a denial, termination or restriction results from such proceedings.

- **Summary Suspension:** Within fifteen (15) days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) days.

The licensee will receive a notice of the proposed action within fifteen (15) days after a peer review body makes a final decision or recommendation. The licensee has the right to submit additional explanatory or exculpatory statements to the licensing board electronically or otherwise. If the provider submits his explanatory or exculpatory statements online, they will be posted for the public to see.

The delegated Credentialing representative, at the request of the QM/Credentialing Committee, will be responsible for tracking the timeframes discussed above and assist in the preparation of 805 and 805.01 Reports for submission to the Medical Board of California. Once the 805 and 805.01 Report is signed by the QM/Credentialing Committee Chair or Medical Director, the delegated Credentialing representative will transmit via U.S. mail or fax; the signed report to the MBC.

821.5 REPORTS

Actions Requiring Reports: A report will be filed with the diversion program of the Medical Board of California whenever IPA, QM Committee or the QM/Credentialing Committee initiates a formal investigation of a physician's ability to practice medicine safely, based upon information indicating that he/she may be suffering from a disabling mental or physical condition that poses a threat to patient care.

Timeframe for filing an 821.5 Report: This report will be filed within fifteen (15) days of initiating the formal investigation. No hearing rights will be afforded prior to filing such a report.

Report of Completion of Investigation: A report will also be sent to the Diversion Program of the Medical Board of California when the investigation has been completed or closed.

The delegated Credentialing representative, at the request of the QM/Credentialing Committee, will be responsible for tracking the timeframes discussed above and assist in the preparation of an 821.5 Report for submission to the Medical Board of California. Once the 821.5 Report is signed by the QM/Credentialing Committee Chair or Medical Director, the delegated Credentialing representative will transmit via U.S. mail or fax; the signed report to the MBC.

NATIONAL PRACTITIONER DATA BANK (NPDB) REPORTS

Fair Hearing Rights: Except in the event of a summary suspension in effect less than thirty-one (31) days or a surrender or restriction of authority to provide care to patients as provided below, a NPDB Report will never be filed until the practitioner has had the opportunity to either waive or exhaust his/her Fair Hearing rights in accordance with Policy CR 6 Fair Hearing Plan.

Actions Requiring Reports: A NPDB Report will be filed whenever any of the following action is taken by the IPA, QM Committee or the QM/Credentialing Committee involving applicable practitioner types become final:

- An action that is based on the practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the practitioner's authority to provide care to patients for more than thirty (30) days;

- Acceptance of the practitioner's surrender or restriction of authority to provide care to patients while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or professional review action.

Timeframe for filing a NPDB Report: A NPDB Report will be filed within fifteen (15) days from the date the adverse action was taken or authority to provide care to patients is voluntarily surrendered.

Additional Reports: A NPDB Report will be filed when any revision is made to a previously reported adverse action.

The delegated Credentialing representative, at the request of the QM/Credentialing Committee, will be responsible for tracking the timeframes discussed above and assist in the preparation of an NPDB Report for submission to the National Practitioner Data Bank. Once the NPDB Report is signed by the QM/Credentialing Committee Chair or Medical Director, the delegated Credentialing representative will transmit electronically the signed report to NPDB.

FORMS:

None

REFERENCES:

HSMSO CR 6 Fair Hearing Plan
NCQA MCO Standards and Guidelines – Credentialing and Recredentialing

SUBJECT: Organizational Providers (OP) **Policy #:** CR 9
DEPARTMENT: Quality Management/Credentialing

Effective date: April 1, 2006
Revised: February 2007; January 2008; January 2009; May 2009; January 2010; June 2010; October 2010; January 2011; January 2012; January 2013; January 2014; April 2014; January 2015; June 2015; January 2016, January 2017; January 2018, January 2019; January 2020; January 2021, January 2023

PURPOSE:

To describe the credentialing criteria and performance standards that Organizational Providers (OP), formerly Healthcare Delivery Organizations (HDO), must meet to ensure satisfactory quality of care and service for participation for those OP in which the IPA contracts separately (full risk contracts) other than contracts held with managed care organizations.

POLICY:

All contracted Organizational Providers (OP) listed below **as applicable** must meet the Standards of Participation set forth in this policy:

- Hospitals
- Skilled Nursing Facilities
- Home Health Agencies
- Free-Standing Surgical Centers (including family planning clinics performing outpatient surgeries)
- Hospice
- Clinical Laboratories
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Outpatient Physical Therapy Providers
- Outpatient Speech Pathology Providers
- End-stage Renal Disease Services Providers
- Outpatient Diabetics Self-Management Training providers
- Portable X-ray Supplier
- Rural Health Clinics (RHC),
- Federally Qualified Health Centers (FQHC)

The IPA requires all OP with which it intends to contract with directly to meet its Standards of Participation.

These Standards are reviewed annually or more frequently as established by state and federal regulation and/or accreditation standards set forth by NCQA.

The QI/Credentialing Committee is responsible for oversight and approval of the OP-as delegated by the Board of Directors. This committee can approve, decline, suspend or terminate an initial credentialing or recredentialing application in accordance with the Credentialing and Recredentialing policies.

DEFINITIONS:

Accrediting Body: A nationally recognized organization which provides review of an OP to assure compliance with published standards and guidelines. The recognized and accepted accrediting bodies are:

The Joint Commission (JTC): applicable for hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, comprehensive outpatient rehabilitation facilities, and hospices.

Healthcare Facilities Accreditation Program (HFAP): applicable for hospitals.

Community Health Accreditation Program (CHAP): applicable for home health agencies and hospices.

Commission on Accreditation of Rehabilitation Facilities (CARF): applicable for skilled nursing facilities and comprehensive outpatient rehabilitation facilities.

Continuing Care Accreditation Commission (CCAC): applicable for skilled nursing facilities.

American Osteopathic Association (AOA): applicable for hospitals.

Accreditation Association for Ambulatory Health Care (AAAHC): applicable for free-standing surgical centers.

American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF): applicable for free-standing surgical centers.

Clinical Laboratory Association Improvement Amendment (CLIA): applicable for clinical laboratories.

Commission on Office Laboratory Accreditation (COLA): applicable for clinical laboratories

American Association of Diabetes Educators (AADE): applicable for outpatient diabetes self-management training providers.

Indian Health Service (IHS): applicable for outpatient diabetes self-management training providers.

Federal Drug Administration (FDA) Certification: applicable to portable x-ray suppliers.

Department of Health Services for the State of California (DHS): - The State body responsible for licensing and providing oversight of healthcare organizations throughout the State of California. The DHS does not count as accreditation of an OP. Whereby the OP is non-accredited, a copy of the DHS report entitled, "Statement of Deficiencies/Plan of Correction" is acceptable in lieu of a site visit if certain conditions are met.

STANDARDS OF PARTICIPATION:

Primary verification is not required. All information used for assessing Organizational Providers must be validated within one-hundred-and-eighty (180) calendar days of the QM/Credentialing Committee review.

- Provider is in good standing with state and federal regulatory bodies:
  - Copy of current California facility license or permit and expiration date.
    Exception: Physician-owned clinics are not required to be licensed by Department of Public Health (DPH), but they must be approved by an agency approved by the Medical Board of California.
  - Review of the Office of Inspector General Report

- Provider has been reviewed and approved by an accrediting body. Copy of current and valid accreditation. The following accrediting bodies are accepted for the different types of Organizational Providers.

  The Joint Commission (TJC): applicable for hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, comprehensive outpatient rehabilitation facilities, and hospices.

  Healthcare Facilities Accreditation Program (HFAP): applicable for hospitals.

  Community Health Accreditation Program (CHAP): applicable for home health agencies and hospices.

  Commission on Accreditation of Rehabilitation Facilities (CARF): applicable for skilled nursing facilities and comprehensive outpatient rehabilitation facilities.

  Continuing Care Accreditation Commission (CCAC): applicable for skilled nursing facilities.

  American Osteopathic Association (AOA): applicable for hospitals.

  Accreditation Association for Ambulatory Health Care (AAAHC): applicable for free-standing surgical centers.

  American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF): applicable for free-standing surgical centers.

  Clinical Laboratory Association Improvement Amendment (CLIA): applicable for clinical laboratories.

  Commission on Office Laboratory Accreditation (COLA): applicable for clinical laboratories

  American Association of Diabetes Educators (AADE): applicable for outpatient diabetes self-management training providers.

Indian Health Service (IHS): applicable for outpatient diabetes self-management training providers.

Federal Drug Administration (FDA) Certification: applicable to portable x-ray suppliers.

- Site visit for non-accredited facilities

    - For entities not accredited by a recognized body, a copy of the DHS "Statement of Deficiencies with Corrective Action Plan" will be requested and evaluated. Based on the report and the DHS scope of severity level codes, IPA will accept, investigate, or perform a site visit.

      DHS level A-E = Accept and monitor.
      DHS level F-I = Investigate quality of care issues identified.
      DHS level J-L = Perform site visit.

- Non-accredited free-standing surgical center

    - Copy of a certification letter from Medicare stating the facility is certified. In lieu of letter, attestation in file or Medicare certification number on spreadsheet will be acceptable.

- Medicare Certification, copy of Health Care Financing Administration (HCFA) letter granting participation.

    - Mandatory for participants in Medicare programs.
    - Certification does not count as accreditation.

- Professional and General Liability Insurance Coverage

    The following are the minimum levels for all facilities:

    Professional (Malpractice) - Hospital
    $ 3,000,000 per occurrence / $ 10,000,000 in aggregate
    $ 5,000,000 per claim no aggregate

    Professional (Malpractice) - Non Hospital facility
    $ 1,000,000 per occurrence / $ 3,000,000 in aggregate

    General Liability - all facilities
    $ 1,000,000 per occurrence / $ 3,000,000 in aggregate

- Absence of Medicare/Medicaid Sanctions – The IPA will not contract with a provider who has been excluded from government programs.

    - The Department of Health and Human Services, Office of Inspector General (OIG) Exclusions & Reinstatement Reports will be queried by the Credentialing Staff via the website www.oig.hhs.gov.

- Medicare Opt Out Report – for the Medicare line of business – Opt-Out Affidavits Database @ data.cms.gov will be accessed via the website https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z . The IPA will not contract with a provider who has Opted Out of Medicare

- The Excluded Parties List System-EPLS (System for Award Management-SAM) Reports will be accessed via the website www.sam.gov.

- NPI and Medi-Cal Number Database via the website https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a

  a. The results of the search are documented by printing out the query findings and placed in the OP credentialing file.

  b. If an OP is/are Not Medi-Cal enrolled the credentialing coordinator will notify the Provider Services representative to notify and provide the provider with the website to begin the provider enrollment process directly through DHCS or through its contracted health plan representative. This will include all provider types delineated by DHCS. http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

  c. The Credentialing Staff will not complete the credentialing process until the Provider(s) have been enrolled. This is for the Medi-Cal contract.

- CMS Preclusion List
  a. The Credentialing Staff will query the CMS Preclusion List database via the website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html currently, the CMS Preclusion List is being submitted to the IPA groups by their contracted health plan.
  b. The results of the search are documented by printing out the query findings and placed in the OP's credentialing file.
  c. The IPA will not contract with an OP who is on the CMS Preclusion List.

- Quality Improvement Review (Recredentialing)

  Quality of Care reporting is reviewed for sanctions.

PROCEDURE:

A. The initial application or reapplication is requested by the Credentialing staff.

1. The application is reviewed to ensure it meets all of the Standards of Participation prior to contracting or reapplication.

2. If the application is incomplete, the staff will request and obtain the missing documents, prior to QI/Credentialing Committee review.

B. Once the application is complete, the Credentialing staff processes and enters the OP information into the Credentialing database.

C. The delegated credentialing staff member reviews the application against all criteria in this policy and the Credentialing or Recredentialing policy as applicable. She/he will determine if an additional site visit review (DHS) is required. If a site visit has been performed, she/he will obtain a current copy; if no visit has been performed, the IPA or their contracted vendor will conduct a site visit.

D. A report prepared by the delegated credentialing staff member will be categorized as follows:

1. The Organizational Provider meets Standards of Participation - recommend approval. The Medical Director reviews all credentialing files, approving those that meet minimum eligibility requirements (clean files). All files approved by the Medical Director are reflected in the QM/Credentialing Minutes as having been approved without objection on the date of the Medical Director's signature.

2. The Organizational Provider does not meet Standards of Participation – review required.

    a. The application is submitted to the QI/Credentialing Committee for action. The Committee decision will:
        1. Approve Organizational Providers participation.
        2. Request additional information or corrective action plan.
        3. Monitor Organizational Providers for identified concerns.
        4. Deny participation in the network.

All actions will be documented in the QM/Credentialing Minutes.

E. The Credentialing decision is communicated in writing to the Organizational Providers by the Credentialing Department. Provider Contracting is notified of the review determination.

F. **Appeal Rights:**

1. The Organizational Provider has the right to appeal a decision made by the QI/Credentialing Committee. Refer to the CR 6 Fair Hearing Plan.
2. A copy of the appeals process will be provided or made available to the applicant upon request; which is noted on the recruitment cover letter provided to each applicant.

G. **Recredentialing:**

1. Recredentialing is conducted of each Organizational Provider at a minimum of every three (3) years.

2. The Credentialing Department tracks and maintains responsibility for ensuring the timing of the reassessment process.

3. All application information obtained for initial credentialing is obtained for recredentialing of the Organizational Provider.

FORMS:

None

REFERENCES:

HSMSO CR 6 Fair Hearing Plan
NCQA MCO Standards and Guidelines – Credentialing and Recredentialing
CMS Guidelines

Subject: Credentialing/Recredentialing Policy & Procedure – Mid-Level Practitioners
Policy #: CR 10

Department: Quality Management/Credentialing

Effective Date: April 1, 2006
Revised: February 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; January 2014; September 2014; January 2015; February 2016; January 2017; January 2018; January 2019; January 2020; January 2021 , January 2023

PURPOSE:

To establish the credentialing criteria and performance standards that licensed health care providers must meet. These standards are developed to ensure all contracted physicians utilizing mid-level practitioners are monitoring for oversight and safety in providing satisfactory quality of care and service when providing care to patients.

POLICY:

Credentialing will be performed for all identified mid-level practitioners within a contracted practitioner's office. This includes the following:

Physician Assistants (P.A.)
Nurse Practitioners (N.P.)
Clinical Nurse Specialists (C.N.S.)
Certified Nurse Mid-Wives (C.N.M.)

Providers who work exclusively within an inpatient hospital are not subject to this policy.

The use of mid-level practitioners within a contracted practitioner's office must fall within the individual's scope of practice, as determined by the respective licensing board. The responsibility to comply with regulations of the mid-level practitioner's respective licensing board belongs to the supervising physician.

A supervising physician directs the practice of mid-level practitioners. The mid-level practitioners act as an agent for that supervising physician. The orders given and the tasks performed by a mid-level practitioner are considered the same as if the orders and tasks were given and performed by the supervising physician. Unless otherwise specified within specific regulations by the individual licensing board, the orders and tasks may be initiated without the prior approval of the supervising physicians.

An applicant is eligible for acceptance if the practitioner has met an established set of criteria that will aid in demonstrating their ability to provide quality care to the group's members.

The credentialing process is currently part of the Quality Management Plan. Providers must submit to Contract Management (CM) all requested credentialing materials and maintain compliance with all criteria as a condition of continued participation in the Group.

All information evidencing compliance with the criteria may not be more than 180 days old at the time of Credentialing Committee review.

Non-discrimination Policy: No aspect of IPA participation shall be denied on the basis of sex, race, age, creed, color, national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

PROCEDURE:

A. Signed Application and Credentials Authorization and Release Form

a. All mid-level practitioners must complete, sign and date a California Mid-Level Provider Application which includes a Credentialing Authorization and Release Form and Attestation Questionnaire. By signing the application the practitioner:

i. attests to the accuracy of the statements made on the application and information attached to it;
ii. agrees to maintain the Medical Group's credentialing criteria; and
iii. authorizes the release of information relating to his/her qualifications, and agrees to hold harmless all entities who will be providing the requested information in good faith.

b. The practitioner's application must be completed in full and contain statements by applicant regarding:

i. Reasons for any inability to perform the essential functions of the position, with or without accommodation.
ii. Lack of past/present illegal drug use.
iii. History of loss of license and/or felony convictions; and
iv. History of loss or limitation of privileges or disciplinary activity.
v. History of substance abuse.

B. Current unrestricted California License to Practice

a. Must hold and maintain a current and valid California License to practice his/her Profession within the constraints of Section 2113 of the California Business and Professions Code. However, the Credentialing Committee or Medical Director may consider practitioners with license restrictions, so long as the restrictions and limitations on their scope of practice will not hinder the practitioner from complying with his/her contractual and professional obligations.

b. A photocopy of the current unrestricted California License to Practice his/her profession must be submitted with the completed application and maintained in the provider's file.

c. Physician Assistants: The license will be primary verified with the Medical Board of California. The primary-source verifications may be done by accessing the board directly via the applicable primary source website or via telephone. If via internet, the screen is printed and initialed by the Credentialing staff. If by phone, a telephone primary verification form is completed which must include name and title of person spoken to, date and name of caller and the information discussed. When verification is received, it is noted on the Credentialing Checklist and placed in practitioner's file.

d. Nurse Practitioners, Clinical Nurse Specialists or Certified Nurse Midwives: The license will be verified with the California Board of Registered Nursing. The primary-source verifications may be done by accessing the board directly via the applicable primary source website or via telephone. If via internet, the screen is printed and initialed by the Credentialing staff. If by phone, a telephone primary verification form is completed that

must include name and title of person spoken to, date and name of caller and the information discussed. When verification is received, it is noted on the Credentialing Checklist and placed in practitioner's file.

e. If the primary source verification indicates any investigation, limitations on scope of practice, restrictions on licensure, sanctions or other action, the information will be requested from the appropriate licensing board in writing.

C. Current unrestricted DEA Certificate if applicable

a. All providers, except non-prescribing providers, must have a valid DEA certificate with a California address. If they do not have a California address on their DEA, then document who will prescribe for the practitioner until they have their California DEA. A photocopy of the DEA Certificate which clearly shows the number and expiration date must be submitted with the completed application.

b. If applicable, a photocopy of the valid DEA Certificate with a California address, which clearly shows the number and expiration date must be submitted with the completed application.

D. All mid-level practitioners must have completed appropriate education and training for practice in the designated specialty.

a. Physician Assistants must have graduated from a Physician Assistant program accredited by the National Commission on Certification of Physician Assistants.

b. Nurse Practitioners must have graduated from a formal, nurse practitioner education program accredited by an accrediting organization recognized by the U.S. Department of Education Division of Accreditation and approved by the California Board of Registered Nursing.

c. Certified Nurse Midwives must have graduated from a formal, midwifery education program accredited by an accrediting organization recognized by the U.S. Department of Education Division of Accreditation and approved by the California Board of Registered Nursing and certified by the American College of Nurse Midwives.

d. Clinical Nurse Specialists must be certified by the California Board of Registered Nursing. To be certified they must have completed an accredited advance practice nursing program or a minimum of four hundred (400) hours of clinical experience concurrently with Master's level course work in the five component areas of competency at any nationally accredited master's/post master's nursing academic program.

E. Primary source verification of Board Certification, if applicable.

F. Effective July 1, 2015, primary source verification of board certification will be obtained if a mid-level practitioner reports that he or she is board certified as indicated below.

a. Physician Assistants: Primary source verification is obtained from the following board:

- National Commission on Certification of Physician Assistants (NCCPA)www.nccpa.net.

b. Nurse Practitioners, Clinical Nurse Specialists or Certified Nurse Midwives : Primary source verification is obtained from one (1) or more of the following boards:

- American Association of Nurse Practitioners (AANP) www.aanp.org
- American Nurses Credentialing Center (ANCC) www.nursecredentialing.org
- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialists (NCC) www.nccwebiste.com
- Pediatric Nursing Certification Board (PNCB) www.pncb.org
- American Association of Critical-Care Nurses (AACN) www.aacn.org

G. There must be a signed agreement, signed by the supervising physician, outlining the specific responsibilities of the mid-level practitioner and the supervising physician. There must be documentation in the file in the form of a signed-off index of the clinical protocols, on-file by the health plan or their delegated entities.

H. At a minimum the last five (5) years of work history must be included on the application and/or C.V. Any discrepancies in work history or gaps of six (6) months or more must be explained.

I. Current certificate of malpractice insurance

a. Mid-level practitioners must maintain $1 million per case and $3 million aggregate minimum professional liability coverage. The application must contain documentation regarding malpractice coverage and amounts.

J. Applicant must provide a history of all professional liability claims.

a. Upon receipt of proof of insurance from practitioner, the Credentialing Specialist will send a letter to the malpractice carrier in order to verify the coverage and also to ask for any claims history.
b. NOTE: CAP/MPT does not provide detailed claims reports for mid-level practitioners.
c. In case of an urgent/rush fast track practitioner(s) that needs to be processed quickly a current copy of the malpractice certificate is acceptable if it includes policy number, limits of coverage, specialty and expiration date.

K. Verification with the National Practitioner Data Bank to identify any sanctions from Medicare/Medicaid, termination of privileges or malpractice suits.

L. Primary source verification of State Sanctions and Restrictions on Licensure and Limitation on Scope of practice from Federation of State Medical Boards (FSMB) to identify any sanctions from other states for PA's only. (i.e. identify any history of license actions including denials, revocations, terminations, suspension, restriction, reductions, limitations on practice, sanctions, probations and non-renewals. Any history of being charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded or have voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on the eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, any federal program or disclosure by application attestation questions)

M. The Department of Health and Human Services, Office of Inspector General (OIG) Exclusions & Reinstatement Reports

a. The Credentialing Staff will query and review the OIG Exclusion and Reinstatement Database at initial credentialing and recredentialing cycles via the website www.oig.hhs.gov.
b. If a provider is matched, a written request for the provider sanction information is sent to:
Office of Investigation; Health Care Administrative Sanctions
Room N2-01-25, 7500 Security Blvd., Baltimore, MD 21244-1850

c. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
d. The IPA will not contract with a provider who has been excluded/sanctioned from government programs.

N. Medi-Cal Suspended and Ineligible Provider List

a. The Credentialing Staff will query and review the Medi-Cal Suspended and Ineligible Provider List at initial credentialing and recredentialing cycles via the website http://www.medi-cal.ca.gov/references.asp
b. The results of the search are documented on the form entitled "Medi-Cal Suspended and Ineligible Report" and placed in the provider's credentialing file.
c. The IPA will not contract with a provider who is suspended or ineligible.

O. Medicare Opt Out Report for Southern California and Northern California – for the Medicare line of business:

a. The Credentialing Staff will access and review the Medicare Opt Out Report at initial credentialing and recredentialing cycles via the website https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z
b. The results of the search are documented on the form entitled "Medicare Opt Out Report Findings" and placed in the provider's credentialing file.
c. The IPA will not contract with a provider who has Opted Out of Medicare.

P. The Excluded Parties List System-EPLS (System for Award Management-SAM) Reports

a. The Credentialing Staff will query and review the SAM (System for Award Management) Database at initial credentialing and recredentialing cycles via the website www.sam.gov.
b. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
c. The IPA will not contract with a provider who has been debarred from participating in government contracts.

Q. The NPI and Medi-Cal Number
a. The Credentialing staff will query and review the NPI and Medi-Cal number Database at initial credentialing and recredentialing cycles via the website https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017/resource/d7cd2c98-3454-46c5-810b-b5436b54de3a
b. The results of the search are documented by printing out the query findings and placed in the provider's credentialing file.
c. If a mid-level(s) is/are Not Medi-Cal enrolled the credentialing coordinator will notify the Provider Services representative to notify and provide the practitioner with the website to begin the provider enrollment process directly through DHCS or through its contracted health

plan representative. This will include all provider types delineated by DHCS. http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

d. The Credentialing Staff will not complete the credentialing process until the Practitioner(s) have been enrolled. This is for the Medi-Cal contract.

R. CMS Preclusion List
   a. The Credentialing Staff will query the CMS Preclusion List database via the website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html currently, the CMS Preclusion List is being submitted to the IPA groups by their contracted health plan.
   b. The results of the search are documented by printing out the query findings and placed in the practitioner(s) credentialing file.
   c. The IPA will not contract with a practitioner who is on the CMS Preclusion List and it will terminate any practitioner(s) that are currently contracted.

S. The following requirements must be met in order for the Committee to recommend appointment to the Group:

   a. Acceptable compliance with general initial credentialing criteria.
   b. An agreement signed by the mid-level practitioner and the supervising physician.
   c. Provider is supportive of the philosophy and concept of managed care and the Group.
   d. Specific Exceptions Require Review & Sign-Off by the Medical Director.
      i. Three (3) malpractice cases over $30,000 within seven (7) consecutive years; or
      ii. One (1) malpractice case over $100,000 within seven (7) consecutive years.
      iii. Medical Record Review score of less than 80% within two (2) years.
      iv. Non-compliance with a corrective action plan.

T. The completed file, including all credentialing information, is submitted to the QM/Credentialing Committee within 180 days of the submission of the completed/signed application for review and recommendation to the Board of Directors for final determination.

U. However, if the committee is disinclined to make a favorable recommendation based either of the two factors listed below, the matter shall be referred to the Quality Management Committee for consideration and a recommendation, as well as possible implementation of the Fair Hearing Plan, before it is submitted to the Board of Directors for final action:

   a. A perceived medical disciplinary cause or reason, indicating the potential for a practitioner's conduct to be detrimental to patient safety or to the delivery of patient care or

   b. Perceived conduct or professional competence which affects or could affect adversely the health or welfare of a patient or patients

V. If the Quality Management Committee determines that neither of the above factors exists or should be cited as grounds for denial, it shall refer the matter back to the QM/Credentialing Committee for further consideration and transmittal of final recommendation to the Board of Directors.

W. The completed file, including all credentialing information, is submitted to the Medical Director, or designee, for review prior to being submitted to the QM/Credentialing Committee. Upon his/her review, the file is then submitted to the QM/Credentialing Committee within 180 days of the provider's attestation and dates of primary verifications for review.

   a. If the applicant is approved, an approval letter is sent to the applicant within sixty (60) days.

b. A copy of the appeals process will be provided or made available to the applicant upon request; which in noted on the recruitment cover letter provided to each applicant.

c. If the applicant is denied, a letter of denial is sent within sixty (60) days to the applicant by certified mail, return receipt requested. An applicant who has been denied is not eligible to reapply for a period of one year. Exceptions may be made based on the need for providers in the applicant's area of practice or when incomplete information was obtained with the original application. A second application is processed as an initial application.

X. Recredentialing

a. Recredentialing of mid-level practitioners is conducted every three (3) years. The Credentialing Department tracks and maintains responsibility for ensuring the timing of the reassessment process.

b. All application information and verifications obtained for initial credentialing is obtained for recredentialing of mid-level practitioners.

c. A Provider Quality Profile is maintained in each provider's file and contains information from the following sources:

i. review of data from member complaints,
ii. results of quality reviews,
iii. utilization reviews,
iv. member satisfaction surveys,
v. medical record reviews (if applicable), and
vi. results of site visits (if applicable)

Y. Follow-Up Between Credentialing Cycles

a. On a monthly basis, credentialing staff query the existing provider database for sanctions or limitation on licensure, DEAs, malpractice insurances and board certifications that are due to expire within the following month.

b. Credentialing staff requests and obtains current information regarding these documents from each provider.

c. In addition to obtaining hard copies, Credentialing Staff will access the online verification systems for medical license, DEAs and board certification to obtain verifications within thirty (30) days of expiration

NON-DISCRIMINATORY CREDENTIALING:

The IPA monitors and prevents discriminatory credentialing through the following processes:

1. Tracking and trending of reasons for denial and/or terminations.
2. Semi-annual audit of files in process for greater than six (6) months to determine compliance with practitioner contract criteria.
3. The presence of a nondiscrimination statement on the "Provider Panel Confidentiality Statement" to be signed by UM/QM/Credentialing Committee members.

4. Documents and/or information submitted to the QM/Credentialing Committee for approval, denial or termination do not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, type of procedures performed or payor sources.

FORMS:

California Participating Mid-Level Application
California Participating Mid-Level Reapplication

REFERENCES:

HSMSO CR 1 Credentialing Policy & Procedure – Physicians
NCQA MCO Standards and Guidelines – Credentialing and Recredentialing

Subject: Qualifications for HIV/AIDS Specialist **Policy #:** CR 11
Department: Quality Management/Credentialing

Effective Date: April 2006
Revised: February 2007; June 2007; January 2008; January 2009; November 2009; January 2010; January 2011; January 2012; January 2013; January 2014; May 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020; January 2021, January 2023

PURPOSE:

To identify additional qualifications for credentialing an HIV/AIDS Specialist for standing referrals and to satisfy California legal requirements relating to the "Standing Referral to HIV/AIDS Specialist" Act.

POLICY:

I. To become a credentialed HIV/AIDS Specialist, a physician must hold a valid, unrevoked and unsuspended certificate to practice medicine in California and must meet any one of the following four (4) criteria:

A. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or

B. Is board certified in the field of HIV medicine by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification in HIV medicine; or

C. Is board certified in the field of infectious diseases and meets the following qualifications;

1. In the immediately preceding twelve (12) months has provided continuous and direct medical care to a minimum of 25 patients who are infected with HIV; and
2. In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients, including a minimum of five (5) hours relating to antiretroviral therapy per year; or

D. Meets the following qualifications:

1. In the immediately preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are infected with HIV; and

2. Has completed any of the following:
   a. In the immediately preceding twelve (12) months has obtained board certification or recertification in the field of infectious disease; or
   b. In the immediately preceding twelve (12) months has successfully completed a minimum of thirty (30) hours of Category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients; or
   c. In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

II. The HIV/AIDS Specialist may utilize the services of a nurse practitioner or a physician assistant if he/she meets the qualifications defined in CR 10 Credentialing Mid-Level Practitioners; and if:

A. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS Specialist; and
B. The nurse practitioner or physician assistant meets the qualifications specified above in Section I D; and
C. The nurse practitioner or physician assistant and that practitioner's supervising HIV/AIDS Specialist have the capacity to see an additional patient.

PROCEDURE:

I. Once it has been identified that a provider is designated as an HIV/AIDS Specialist, a "Verification of Qualifications-HIV/AIDS Physician Specialists" form will be sent to the physician either by fax or mail.

A. If the physician is not credentialed as a HIV Specialist by the AAHIVM, he/she must meet one of the other qualifications cited on the form and copies of the required continuing medical education (CME) certificates must accompany the completed form. A list of the CME programs attended, stating the CME dates, content and number of hours for each program, may be substituted for the certificate copies.
B. If the physician has successfully completed the HIV Medicine Competency Maintenance Examination administered by the AAHIVM, a copy of the certificate or letter verifying successful test completion shall be obtained; or, verification may be obtained from AAHIVM.
C. If the physician is credentialed as a HIV Specialist by the AAHIVM, his/or status shall be verified with the AAHIVM Website and a copy of the verification shall be printed and placed in the credentials file.

II. If it is identified on the physician's application that he/she utilizes nurse practitioner(s) and/or physician assistant(s), the nurse practitioner(s) and/or physician assistant(s) must hold a valid, unrevoked and unsuspended certificate to practice in California and must submit the following items in addition to a credentialing application with required addenda and attachments:

A. A completed, signed and dated "Verification of Qualifications HIV/AIDS Allied Health Specialists" form, which is placed within the credentialing file.
B. Copies of the required Category 1 CME units for nurse practitioners recognized by the California Board of Registered Nursing and for physician assistants approved by the American Association of Physician Assistants must accompany the completed form. A list of the CME programs attended, stating the CME dates, content and number of hours for each program, may be substituted for the certificate copies.
C. If the nurse practitioner or physician assistant has successfully completed the HIV Medicine Competency Maintenance Examination administered by the AAHIVM, a copy of the certificate or letter verifying successful test completion is requested; or verification may be obtained from AAHIVM.

III. Once a provider has been identified as a qualifying physician, it is noted on the IPA roster which is posted on the internal IS drive that is accessed by the UM/Case Management Departments when authorizing standing referrals of HIV specialists.

IV. On an annual basis, the credentialing staff will send the "Verification of Qualifications-HIV/AIDS Physician Specialist" form via fax to each provider that has been identified as an HIV/AIDS provider(s) in the network.

A. The verification date will be maintained in the Credentialing Database and copy of form placed in the provider's file.
B. It is noted on the IPA roster which is posted on the internal IS drive that is accessed by the UM/Case Management Departments when authorizing standing referrals to HIV Specialists.
C. Annually, a list of the verified HIV/AIDS Specialists is presented to the QM/Credentialing Committee.

FORMS:

Verification of Qualifications of HIV/AIDS Physician Specialist Form
Verification of Qualifications of HIV/AIDS Allied Health Specialist Form

REFERENCES:

None

SUBJECT: Monitoring and Sanctioning **Policy #:** CR 12
DEPARTMENT: Quality Management/Credentialing

Effective Date: April 1, 2006
Revised: August 2006; February 2007; March 2007; January 2008; January 2009; January 2010; January 2011; January 2012; January 2013; October 2013; January 2014; April 2014; September 2014; January 2015; January 2016; January 2017; January 2018; January 2019; January 2020**; January 2021, January 2023**

PURPOSE:

To describe the process for monitoring of provider sanctions and complaints between recredentialing cycles.

DEFINITIONS:

Adverse Event: An injury to a member that happened while receiving healthcare services from a practitioner.

POLICY:

The IPA performs ongoing monitoring of provider sanctions and complaints between recredentialing cycles

The following agencies/reports are reviewed monthly by the Credentialing Department for actions against providers:

- Medical Board of California (MBC) Disciplinary Actions
- License Reports from appropriate specialty boards
- Medi-Cal Sanction Report from the Department of Health and Human Services
- Office of Inspector General (OIG)
- Medicare Opt-Out Report - Opt-Out Affidavits Database at data.cms.gov
- Excluded Parties List System-EPLS (System for Award Management-SAM) Reports
- CMS Preclusion List

For entities that do not publish sanction reports, the sanctions will be queried individually for any practitioner within twelve (12) to eighteen (18) months after last credentialing cycle.

The IPA will not contract with a provider that has opted out of Medicare, appears in the OIG Exclusion Database or on the Excluded Parties List System-EPLS (System for Award Management-SAM) Reports.

Health Plans are notified immediately of any provider excluded/sanctioned from participation in federal programs.

On a quarterly basis, the Credentialing Department reviews all quarterly aggregate member complaints reports for the purpose of identifying any providers whose history suggests that a trend exists. When applicable, this information is reported to the QM/Credentialing Committee.

PROCEDURE:

A. Licensing Boards and Agencies

Each month, within thirty (30) days of release, the Credentialing Department checks for contracted providers whose name may appear on any of these lists: Medical Board of California (MBC) Disciplinary Actions; License Reports from appropriate specialty boards; Department of Health and Human Services, Office of Inspector General (OIG) Exclusion and Reinstatement Reports; Medicare Opt-Out Report for Southern and Northern California; Excluded Parties List System-EPLS (System for Award Management-SAM) Reports; and Medi-Cal Sanction Report from the Department of Health and Human Services.

The Credentialing staff will download and review any identified actions within thirty (30) days of release of those reports containing these actions. Information will be presented to the QM/Credentialing Committee for review and potential action.

1. Medical Board of California (MBC) Disciplinary Actions
   On an on-going basis, the MBC notifies the Credentialing Department via electronic mail of any providers that have any actions filed against his/her medical license. Within thirty (30) days of receipt, it is checked against the providers that are part of the IPA panel in the Data Management System.

   a. If a provider appears with a Disciplinary Action, the Credentialing staff obtains the documentation for the actions taken via appropriate Board or Agency website, if available, or through a letter sent directly to the appropriate Board or Agency.
   b. A letter is also sent to the affected provider requesting an explanation of the action.
   c. The provider is added to the Sanction Activity Monitoring Log.
   d. Information will be presented to the QM/Credentialing Committee for review and potential action.

2. Review of License Reports from appropriate specialty boards
   (i.e. California Board of Chiropractic Examiners, California Board of Registered Nursing, Dental Board of California, California State Board of Optometry, California Board of Behavioral Sciences, Osteopathic Medical Board of California and California Speech-Language Pathology and Audiology Board, Physical Therapy Board of California and Board of Occupational Therapy)

   Specialty Boards that do not publish sanction information on a set schedule will be queried for this information at least every six (6) months.

   a. If a provider appears with a Disciplinary Action, the Credentialing staff obtains the documentation for the actions taken via appropriate Board or Agency website, if available, or through a letter sent directly to the appropriate Board or Agency.
   b. A letter is also sent to the affected provider requesting an explanation of the action.

c. The provider is added to the Sanction Activity Monitoring Log.
d. Information will be presented to the QM/Credentialing Committee for review and potential action.

3. Department of Health and Human Services, Office of Inspector General (OIG) Exclusion and Reinstatement Reports

   On a monthly basis, within thirty (30) days of release, the Credentialing staff accesses the OIG website at www.hhs.gov/oig/cumsan and downloads the current Exclusion and Reinstatement Reports. The providers on the Report are matched against the providers that are part of the IPA.

   a. If a provider is matched, a written request for the provider sanction information is sent to:

      Office of Investigation; Health Care Administrative Sanctions
      Room N2-01-25, 7500 Security Blvd., Baltimore, MD 21244-1850

   b. If a provider is excluded/sanctioned. from federally funded healthcare programs, provider will be automatically terminated from the IPA (refer to CR 5 Reduction, Suspension, Termination of Provider Status) and an alert is placed in the Data Management System so no payments are made to these providers.

4. Medicare Opt Out Report for Southern California and Northern California – for the Medicare line of Business – Opt-Out Affidavits Database:

   On a quarterly basis, within thirty (30) days of release, the Credentialing staff accesses the website at https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z and prints out the quarterly listings. The providers on the list are matched against the providers that are part of the IPA.

   a. If a provider appears on the Medicare Opt Out Report for Southern California or Northern California, provider will be automatically terminated from the IPA (refer to CR 5 Reduction, Suspension, Termination of Provider Status) and an alert is placed in the Data Management System so no payments are made to these providers.

5. Excluded Parties List System-EPLS (System for Award Management-SAM)

   This report identifies parties excluded throughout the U.S. Government from receiving Federal contracts or certain subcontracts and from certain type of Federal financial and non-financial assistance and benefits is downloaded monthly, within thirty (30) days of release, from the website www.sam.gov and is matched against the providers that are part of the IPA.

   a. If a provider appears on the Excluded Parties List System-EPLS (System for Award Management-SAM) Reports, provider will be automatically terminated from the IPA (refer to CR 5 Reduction, Suspension, Termination of Provider Status) and an alert is placed in the Data Management System so no payments are made to these providers.

6. CMS Preclusion List

   This list is published by CMS and is being submitted currently by the IPA's current contracted health plan. It identifies a list of prescribers and individuals or entities who are currently revoked from Medicare, who have engaged in behavior for which CMS could have revoked the prescriber, individual or entity. Such conduct includes, but are not limited to, felony convictions and Office of Inspector General (OIG) exclusions.

   a. If a provider appears on the CMS Preclusion List, provider will be automatically terminated from the IPA (refer to CR 5 Reduction, Suspension, Termination of Provider Status) and an alert is placed in the Data Management System so no payments are made to these providers.

7. Medi-Cal Suspended and Ineligible Provider List

   This list is published by DHS and updated monthly. It identifies suspended, excluded and otherwise ineligible providers. On a monthly basis, within thirty (30) days of its release, the list is reviewed for IPA providers. If a match is found, documentation of the actions is requested from DHS and an explanation is required of the practitioner.

   a. If a provider appears on the Medi-Cal Suspended and Ineligible Provider List, provider will be automatically terminated from the IPA (refer to CR 5 Reduction, Suspension, Termination of Provider Status) and an alert is placed in the Data Management System so no payments are made to these providers.

B. Member Complaints

   The Quality Management Department will provide a quarterly report to the Credentialing Department, which includes the names of practitioners with member complaints for the previous quarter as well as the year-to-date aggregate number of complaints.

C. Quality Issues / Adverse Events

   The Quality Management Department will provide a quarterly report to the QM/Credentialing Committee, which will include information from identified adverse events. The QM/Credentialing Committee will implement the appropriate policy-based action or intervention when an incidence of poor quality is identified that could affect the health and safety of its members.

D. Quarterly Reporting to the QM/Credentialing Committee

   On a quarterly basis, an on-going monitoring report is presented to the QM/Credentialing Committee for providers that have actions against them, along with a report from Member Services which includes names of practitioners with complaints with year-to-date aggregate number of complaints.

FORMS:

None

REFERENCES:

HSMSO CR 5 Reduction, Suspension or Termination of Provider Status
NCQA MCO Standards and Guidelines – Credentialing and Recredentialing
CMS Guidelines

MID-LEVEL PROVIDER APPLICATION

ATTACHMENT I: STATEMENT OF AGREEMENT BY SUPERVISING PROVIDER

Name: _____ **Employed as:** _____
Mid-Level Provider

Name: _____
Supervising Provider

I, _____ supervising Provider for the above named Mid-Level Provider, do hereby make the following statements of agreement in accordance with the policies/procedures regulating the Mid-Level Provider program:

1. I hereby accept full legal and ethical responsibility for the performance of all duties and acts performed by the above named Mid-Level Provider whom I have employed.

2. I hereby request approval to allow above named Mid-Level Provider to perform, outside my immediate supervision, the specific activities and duties, as outlined in the ***attached supervising guidelines and/or job description of the Mid-Level Provider***.

3. I agree to immediately notify IPA/Medical, in writing, in the event my approval to supervise an Mid-Level Provider is removed, limited or otherwise altered by action of the Medical Board of California, or in the event of any notification of investigation of my supervision by the Board, or if there is a change in employment status of the Mid-Level Provider hereby applying.

4. I agree to inform all patients that said Mid-Level Provider will participate in the total care of the patient and agree to ensure that the Mid-Level Provider will be clearly identified by badge.

5. I agree to comply with all regulations and policies of the Medical Board of California and/or other regulating agencies and IPA/Medical with respect to the supervision of the Mid-Level Provider, specifically including such regulations and policies which have been or may, from time to time, be adopted by said Board and/or other regulating agencies and IPA/Medical with respect to:

   a. Billing for the services of the Mid-Level Provider;

   b. Requirements for supervision of the Mid-Level Provider with respect to the type and scope of services approved by the Medical Board of California for the Mid-Level Provider to perform; and

   c. Requirement for identification of the Mid-Level Provider while rendering services.

   It is understood that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by IPA/Medical of the performance of services by the Mid-Level Provider for the health plan.

6. I understand the right of the Mid-Level Provider to render medical services under my contract shall be contingent upon my continued membership and contract with IPA/Medical. If I terminate my membership or contract, or if my membership or contract is suspended, revoked or terminated, the Mid-Level Provider's clinical activities shall automatically be changed accordingly. Similarly, if my membership or contract is restricted, the Mid-Level Provider's activities shall be restricted accordingly.

7. If applicable, a certificate issued to me by the Medical Board of California indicating my approval to supervise a Mid-Level Provider in the type and scope of practice for which this application has been made is attached.

8. I understand that the above named Mid-Level Provider shall have only such authority as is necessary to perform the duties and tasks indicated in this application. Questions of authority shall be referred to me for case by case resolution.

_____ _____
Supervising Provider 's Signature Date

NON-PHYSICIAN MEDICAL PRACTITIONER
PRACTICE PROTOCOLS

_____ for _____ has adopted the following Medical books, as the protocols and clinical practice guidelines:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

The current edition of these medical books shall provide the standards for the subjective and objective data that should be obtained from patients for each of the diseases included within them. The protocols for the management of patients with any of the included disease shall be as it is outlined in these medical books.

As an agent of the supervising physician, the mid-level provider is authorized to provide, administer, or initiate an order for a service, drug, device, or procedure specified in the protocols without a patient specific order. Except as provided below, the mid-level provider may initiate orders for the patient care services indicated in these medial books without prior consultation with the supervising physician.

Physician consultation or referral is indicated for the management of patient that have diseases which are not included in these medical books and regarding any patient, task, procedure, or diagnostic problem that the mid-level provider determines exceeds his level of competence.

A physician assistant may only administer, provide or transmit a drug order for Schedule II through Schedule V controlled substances with the advance approval by supervising physician for the specific patient unless a physician assistant completes an approved education course in controlled substances, and if delegated by the supervising physician. If a physician assistant chooses not to take the educational course, the requirements for patient-specific authority remain unchanged.

Mid-level Provider Name (Printed)	Mid-level Provider (Signature)	Date
Supervising Physicians Name (Printed)	Supervising Physician (Signature)	Date

SUPERVISING PHYSICIAN'S RESPONSIBILITY
FOR NON-PHYSICIAN MEDICAL PRACTITIONER

SUPERVISOR,_____, is licensed to practice in California as a physician and surgeon with medical license number _____ ___. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The NPMP named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the NPMP for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF NPMP SUPERVISION. Each time the Non-Physician Medical Practitioner (NPMP) provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the NPMP shall also enter the name of his or her supervising physician who is responsible for the patient. When the NPMP transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a **check mark (x),** shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the NPMP named

_____ Examination of the patient by a supervising physician the same day as care is given by the NPMP.

_____ The supervising physician shall review, audit, and countersign every medical record written by the NPMP within _____ of the encounter.
(Number of Days May- Not Exceed 30 Days)

_____ The physician shall audit the medical records of at least 5% of patients seen by the NPMP under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

_____._____ Phone: _____
(Printed Name and Specialty)

_____ Phone: _____
(Printed Name and Specialty)

PROTOCOLS NOTE: This document **does not** meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

_____ _____
Date Physician's Signature

DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

Non-Physician Medical Practitioner _____
(Name)
Non-Physician Medical Practitioner, graduated from the _____on _____.
(Name of Training Program) (Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on _____.
(Date)

He/she was first granted licensure by the Physician Assistant Committee or Board of Registered Nursing on ____ _____, which expires on _____, unless renewed.
(Date) (Date)

SUPERVISION REQUIRED. The Non-Physician Medical Practitioner named above (hereinafter referred to as NPMP) will be supervised in accordance with the written supervisor guidelines required by Section 1399.545 of the Physician Assistant Regulations or California Code of Regulations, Article 7 Section 1474. The written supervisor guidelines are incorporated with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The NPMP is authorized by the physician whose name and signature appear below to perform all the tasks set forth below, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc. the NPMP and *supervising* physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The NPMP is authorized to perform the following laboratory and screening procedures:

_____

_____

The NPMP is authorized to assist in the performance of the following laboratory and screening procedures:

_____

_____

The NPMP is authorized to perform the following therapeutic procedures:

_____

_____

The NPMP is authorized to assist in the performance of the following therapeutic procedures:

_____

_____

The NPMP is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

_____

_____

The NPMP is authorized to write and sign drug orders for Schedule: II, III, IV, V (circle appropriate).

DEA# _____

CONSULTATION REQUIREMENTS. *The NPMP is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; NPMP 's uncertainty of diagnosis; patient's desire to see physician; any conditions which the NPMP feels exceeds his/her ability to manage, etc.)*
See attached

(List Types of Patients and Situations)

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. *The NPMP may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.*

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. _____ *YES* _____ *NO*

The NPMP may also enter a drug order on the medical record of a patient at _____
(Name of Institution)
in accordance with the Physician Assistant Regulations or Nurse Practice Act and other applicable laws and regulations. Any medication handed to a patient by the NPMP shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. *All approved tasks may be performed for care of patients in this office or clinic located at* _____ *and, in* _____ *hospital(s) and*
(Address / City) *(Address / City)*

_____ *skilled nursing facility (facilities) for care of*
(Name of Facility)

patients admitted to those institutions by physician(s) _____ .
(Name/s)

EMERGENCY TRANSPORT AND BACKUP. *In a medical emergency, telephone the 911 operator to summon an ambulance.*

The _____ *emergency room at* _____
(Name of Hospital) *(Phone Number)*
is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.
Notify _____ *at* _____ *immediately (or within* _____ *minutes).*
(Name of Physician) *(Phone Number/s)*

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

_____ _____
Date Physician's Signature (Required)

_____
Physician's Printed Name

_____ _____
Date Mid Level's Signature (Required)

_____
Mid Level's Printed Name

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid-Orange County
C/O: HealthSmart Management Services Organization, Inc.
PO Box 6300, Cypress, CA 90630-0063
Phone: (714) 947-8600; Fax: (714) 947-8708

Re: Minimum Physician Standards

Dear Provider,

Noble Community Medical Associates, Inc. of Mid-Orange County adopted a set of Minimum Physician Standards for first time credentialing applicants to include the following:

- Valid California license to practice medicine
- Current professional liability insurance
- Able to fully participate in State of Federal Health care program
- No felony convictions within the 10 years prior to applying
- Never been excluded from participating in State or Federal programs
- Applicant physician must not currently be on probation for any reason
- Applicant must not have an Accusation pending before their licensing Board.

Therefore, as part of our pre-screening process, please complete the attached Minimum Physician Standard Attestation, sign and fax back to Provider Services department at 714-947-8708 or email to providerservice@healthsmartmso.com.

If you have any questions, please call us at (714) 947-8600.

Sincerely,
HealthSmart Management Services Organization, Inc.

Provider Services/Contracting

cc: credentialing file

Noble Community Medical Associates, Inc. of Mid-Orange County
Minimum Physician Standards Attestation

Noble Community Medical Associates, Inc. of Mid-Orange County's ("IPA") has implemented "minimum physician standards" for medical doctors, Doctor of Osteopathic Medicine, and doctors of podiatric medicine, who wish to contract with the IPA to provide services to its members. All physicians in these categories who wish to participate in the IPA program must meet all minimum physician standards in order to submit an application for credentialing, the successful approval of which is a pre-requisite to contracting with the IPA. All potential providers who have not contracted with the IPA prior to June 1, 2016 must submit this Attestation in order to be considered for issuance of a credentialing application.

Please answer the following questions either Yes (Y) or No (N)

A. Do you have a current valid California license to practice the profession for which you are seeking participation in the IPA?
Y ☐ **N** ☐

B. Do you possess a current valid DEA certificate? **Y** ☐ **N** ☐

C. (1) Were you certified in your specialty within five years of the completion of your residency training, and do you continue to be so certified, by
Medi-Cal-approved specialty Board, or (2) Has it been less than five years since completion of your residency training, and you have been making adequate progress towards being so certified before the expiration of five years from the completion of your residency training, or (3) Were you first license to practice medicine in a United States jurisdiction before January 1, 2008?
Y ☐ **N** ☐

D. Do you have current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of $1 million per occurrence and $3 million aggregate per year that covers all aspects of your practice?
Y ☐ **N** ☐

E. Are you currently excluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs?
Y ☐ **N** ☐

F. Are you currently on probation with the Board that issued your license to practice?
Y ☐ **N** ☐

G. Do you currently have an accusation or other disciplinary proceeding against you with the board that issued your license to practice?
Y ☐ **N** ☐

H. Have you ever been excluded from participating in Federal and/or State health care program based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C & 1396a-79a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care program; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud and/or (4) a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?
Y ☐ **N** ☐

I. Do you have any felony convictions in the ten (10)-year period prior to the date of execution of this questionnaire set forth below?
Y ☐ **N** ☐

By signing this attestation, I hereby: (1) give the IPA permission to investigate and verify the accuracy of any and all statements and representations in this
Attestation; and (2) authorize any relevant person or entity to provide information requested by the IPA that may be related to any and all statements and
representations made in this Attestation.

I declare, under penalty of perjury, under the laws of the State of California, that all statements contained in this Attestation are true and correct. I understand
that any and all statements made in this Attestation are subject to verification and that any false or dishonest statements may grounds for limiting or
terminating your participation in the IPA's programs.

Print Name Here: _____ **License #:** _____

Physician Signature: _____ **Date:** _____
(Stamped Signature is NOT acceptable)

California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Last Name:	First Name:	Middle:

Is there any other name under which you have been known? Name(s):		
Home Mailing Address:		
City:	State:	Zip Code:

Home Phone Number:	Fax Number:	Cell Number:	Pager Number:
Practitioner Email:	Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):		
Birth Date:	Birth Place:	Race/Ethnicity (optional):	
Driver's License State/Number:	Social Security Number:	Gender: ☐ Male ☐ Female	

Your intent is to serve as a(n):

☐ Primary Care Provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital Based

Specialty:
Subspecialties:

III. Practice Information

Practice Name (if applicable):	Department Name (if hospital based):	
Primary Office Address:		
City:	State:	Zip Code:

Telephone Number:	Fax Number:	Website (if applicable):
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:
Federal Tax ID Number:		Name Associated with Tax ID:

Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None

III. Practice Information (Continued)

Type of practice (check all that apply):

☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Primary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Secondary Practice Information

Practice Name (if applicable):		Department Name (if hospital based):	
Secondary Office Address:			
City:		State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	

Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None

Type of practice (check all that apply):

☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Tertiary Practice Information

Practice Name (if applicable):		Department Name (if hospital based):
Tertiary Office Address:		
City:		Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:
Federal Tax ID Number:		Name Associated with Tax ID:
Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐None		
Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care ☐ Single Specialty Group ☐ Multi Specialty Group		
Tertiary Office Hours of Operation:	Languages spoken by Staff:	
	Languages spoken by Provider:	
Group Medicare PTAN/UPIN #:	Group NPI #:	

Mailing Address

Which of your practices is your primary mailing address? ☐ Primary ☐ Secondary ☐ Tertiary ☐ Other	
If your mailing address is different from your practice address, please provide it:	

IV. Billing Information

Which of your practices handles your billing? ☐ Primary ☐ Secondary ☐ Tertiary, if none, please provide billing info:		
Billing Company:		
Billing Company Mailing Address:		
City:	State:	Zip Code:
Contact Person:	Telephone Number:	
Federal Tax ID Number:	Name Associated with Tax ID:	

V. Practice Description

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ☐Yes ☐No
If so, please list:

Name	Type of Provider	License Number
Physician Assistant Supervisor Name:	License Number:	

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ☐Yes ☐No
If so, please list:

Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		☐ Primary ☐Secondary ☐Tertiary
		☐ Primary ☐Secondary ☐Tertiary
		☐ Primary ☐Secondary ☐Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:

Which offices does this apply to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this apply to: ☐ Primary ☐ Secondary ☐ Tertiary

Is your practice limited to certain ages? ☐ Yes ☐ No If yes, specify limitation:

Which offices does this apply to: ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company:		
Answering Service Company Address:		
City:	State: Zip Code:	Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

VI. Education, Training, and Experience

Medical/Professional Education

Medical School/Professional:	Degree Received:	Graduation Date:
Mailing Address:	Website(if applicable):	
City:	State: Zip Code:	Registrar's Phone Number:

Internship/PGY-1

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Internship:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

Residencies/Fellowships Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

VII. Medical Licensure & Certifications

California State Medical License: Number	Issue Date:	Expiration Date:
Drug Enforcement Agency (DEA) Registration Number:	Schedules:	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Issue Date:
Individual National Physician Identifier (NPI):	Medi-Cal/Medicaid Number:	Individual Medicare PTAN Number:

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)
Have you applied for board certification other than those indicated on the prior page? ☐ Yes ☐ No			
If so, list board(s) and date(s):			

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:	Describe here:
Board Name:	
Exam Date:	

VIII. Current Hospital and Other Institutional Affiliations

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Secondary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Other Institution Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Other Institution Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

A. *Current Affiliations (continued)*

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):	

B. *Previous Hospital and Other Institutional Affiliations*

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

IX. Peer References

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility where you currently hold privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

X. Work History

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

Previous Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

Previous Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

XI. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐ Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:
Name of Previous Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐ Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

Name of Previous Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐ Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

XII. Professional and Practice Services

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐ Yes ☐ No

What type of anesthesia do you provide in your group/office?

☐ Local ☐Regional ☐ Conscious Sedation ☐General ☐None ☐Other (please specify):

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID:	Type of Service Provided:	Do you have a CLIA certificate? ☐Yes ☐No
Billing Name:		Do you have a waiver? ☐Yes ☐No
CLIA Certificate Number:	CLIA Certificate Expiration Date:	

XII. Professional and Practice Services (continued)

☐ Check if there are any changes and update below.

Have you or your office received any of the following accreditations, certificates or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)

☐ Medicare Certification

☐ Child Health and Disability Prevention Program (CHDP)

☐ California Children Services (CCS)

☐ The Medical Quality Commission (TMQC)

☐ Comprehensive Perinatal Services Program (CPSP)

☐ Family Planning

☐ Other:

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ☐Yes ☐No If so, which Network?

Do you use a practice management system/software? ☐Yes ☐No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

☐ 1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**

☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

☐ 1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**

☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**

☐ 3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ☐Yes ☐No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ☐Yes ☐No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ☐Yes ☐No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ☐Yes ☐No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐Yes ☐No

6. Have you ever been denied certification/recertification by a specialty board? ☐Yes ☐No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ☐Yes ☐No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ☐Yes ☐No

8. b.Are any such actions pending? ☐Yes ☐No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If YES, please complete Addendum B. ☐Yes ☐No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending?
If YES, please complete Addendum B. ☐Yes ☐No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ☐Yes ☐No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If YES, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ☐Yes ☐No

Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ☐Yes ☐No

    If YES, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ☐Yes ☐No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ☐Yes ☐No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ☐Yes ☐No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

Continue to the Next Page for Information Release/Acknowledgements

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.
I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.
In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

Addenda Submitting;

☐ Addendum B; Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.
The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address: **PO Box 6300** City: **Cypress, CA** State: **CA** Zip: **90630**

Main Phone: **(714) 947-8600** Credentialing Dept. Fax: **(714) 947-8709**

_____ _____ _____

APPLICANT SIGNATURE (Stamp is Not Acceptable) **PRINTED NAME** **DATE**

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I: Practitioner Identifying Information		
Last Name:	First Name:	Middle:

II. Case Information			
Patient's Name:	Patient's Gender: ☐ Male ☐ Female		Patient's DOB:
City, County, State where lawsuit filed:	Court Case number, if known:	Date of alleged incident serving as basis for the lawsuit/arbitration:	Date suit filed:

Location of incident: ☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify):
Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.)
Allegation:
Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐Yes ☐No
If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name:	Telephone Number:	Fax Number:

III. Status of Lawsuit/Arbitration (check one)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

_____ _____ _____

APPLICANT SIGNATURE (Stamp is Not Acceptable) **PRINTED NAME** **DATE**

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: May 22, 2014

POLICY LETTER (PL) 14-004
SUPERSEDES PL 02-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: SITE REVIEWS: FACILITY SITE REVIEW AND MEDICAL RECORD REVIEW

PURPOSE:
The purpose of this PL is to inform all Medi-Cal managed care health plans (MCP) of the updates to the Department of Health Care Services' (DHCS) site review policy. DHCS previously published this policy in PL 02-002. This revised PL supersedes PL 02-002 and reflects changes made to the criteria and scoring of the Medi-Cal Managed Care Division's (MMCD) Facility Site Review (FSR) Survey Tool and Guidelines (Attachment A) and the Medical Record Review (MRR) Survey Tool (Attachment B) and the use of the Physical Accessibility Review Survey (PARS) Tool (see PL 12-006 Attachment C). PL 12-006 can be found at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-006.pdf.

DHCS updated criteria to reflect current guidelines of professional organizations, unbundled these criteria groups to better identify deficiencies, and adjusted scoring methods to better generalize the scores.

DHCS conducts site reviews to ensure that all primary care provider (PCP) sites, used by MCPs to deliver health care services to MCP members, have sufficient capacity to:

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

BACKGROUND:
In 1991, the Centers for Medicaid and Medicare Services (CMS) stipulated that managed care organizations (MCOs) must adhere to all applicable local, state, and federal laws and regulations. When the MCO contracts with state Medicaid programs, the MCO must have an internal program for quality assurance. The site review process is part of an MCP's quality improvement program that focuses on the capacity of each PCP site to ensure and support the safe and effective provision of clinical services.

CMS requires MCPs to offer a range of services, including preventive and primary care services. Primary care services include all health care and laboratory services customarily provided by a general practitioner, family practice physician, internal medicine physician, pediatrician or obstetrician/gynecologist serving as a PCP in accordance with state licensure and certification laws and regulations (Title 42, Code of Federal Regulations, Section 438).

CMS requires MCPs to have adequate facilities and sufficient site locations available to meet contractual requirements for the delivery of primary care within their service areas. All PCP sites must have the capacity to support the safe and effective provision of primary care clinical services to MCP members (Title 22, California Code of Regulations [CCR], Section 56230).

In 1998, DHCS established a collaborative workgroup, containing representatives from each of the models of managed care, to revise DHCS's site review policy. In 2010, a DHCS workgroup updated the FSR and MRR Survey Tools and Guidelines. The objective of this workgroup was to develop a uniform, system-wide process that clarified the requirements and decreased duplicative site reviews for MCP providers who serve the Seniors and Persons with Disabilities (SPD) population. MCPs began to use the new FSR and MRR tools and guidelines in January 2012.

DHCS published PL 12-006 in 2012 that required MCPs to use the PARS Tool to assess the level of physical accessibility of provider sites, including specialist and ancillary service provider sites that provide care to SPDs. DHCS continues to monitor MCP use of the PARS Tool.

POLICY:
DHCS must review all MCP PCP sites (Title 22 CCR Section 56230). MCPs must ensure that PCP sites comply with all applicable local, state, and federal standards. Each provider site must be appropriately licensed and accredited. Before DHCS approves an MCP to provide services to its members, each of the MCP's contracted or subcontracted PCP sites is subject to an initial site review, and periodic site reviews thereafter consisting of an FSR and MRR, to evaluate the site's capacity to deliver quality services.

Accountability
MCPs are accountable for all activities on PCP sites, whether those services are provided by contracted or subcontracted health plans, independent physician association, or other delegated or sub-delegated entity. MCP accountability includes ensuring that the PCP sites comply with regulatory, contractual, and policy requirements, and that PCP sites complete all necessary corrective actions.

Delegation
DHCS must approve all delegated responsibilities. MCPs are responsible for:

- Identifying specific delegated functions;
- Overseeing and monitoring delegated activities;
- Ensuring that delegated functions are properly carried out; and
- Establishing a formal, mutually agreed upon document.

MCPs may choose whether or not to delegate site review responsibilities to another MCP or appropriate entity. Each collaborating MCP determines whether or not to accept the delegated entity's site review findings.

All delegated and sub-delegated entities must follow the current MMCD site review policy requirements. Site review personnel from delegated and sub-delegated entities must be trained, certified and supervised according to the policy standards established for MCPs.

Credentialing and Recredentialing
MCPs must ensure that providers are credentialed according to MMCD contractual and policy requirements. Each MCP must complete a site review as part of its initial credentialing process when the MCP adds a new provider to its provider network who works at a site the MCP has not previously reviewed. An MCP does not need to repeat a site review as part of the initial credentialing or recredentialing process if a new provider works at a provider site that has a current passing site review score. MCPs may consider a site review "current" if it is dated within the last three years. An MCP does not need to repeat a site review until the due date of its next scheduled site review unless the MCP, through its monitoring activities, determines a site review is necessary. Because network providers change over time, the timeline for provider recredentialing and subsequent site reviews may not be on a synchronized schedule.

Facility Site Review
A site review consists of the MMCD FSR and MRR Survey Tools. All MCPs and subcontracted entities must use MMCD survey criteria and scoring methods to audit facility sites and medical records.

MCPs must complete initial site reviews and subsequent periodic site reviews comprised of the FSR and MRR of all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications (Title 22 CCR Section 56230). MCPs must apply the same standard to conduct site reviews at each PCP site. The most current FSRs and MRRs will be shared among all MCPs contracting with a particular provider. Each MCP is responsible for tracking the survey status of all of its contracted provider sites. MCPs must collaborate locally to determine how they will notify each other of the survey status and results for their shared providers.

I. Initial Site Review
All PCP sites serving MCP members must undergo an initial site review and receive a minimum passing score of 80 percent on the FSR Survey Tool. An initial site review, which does not include an MRR, is the first onsite inspection of a site that has not had a previous review, or is a PCP site that is returning to the Medi-Cal managed care program and has not had a passing review in the past three years. The MCP may waive the initial site review for a pre-contracted provider site if the provider has documented proof that another local MCP completed a site review with a passing score within the past three years.

Prior to initiating operations in a service area, an MCP must complete initial site reviews consisting of the FSR, on five percent of the PCP sites in its provider network, or on 30 PCP sites, whichever is greater in number. The PCP sites reviewed must include a variety of providers from throughout the provider network and from each subcontracted entity. If there are 30 or fewer PCP sites in the network, the MCP must review 100 percent of the sites prior to beginning operations. The MCP must complete an initial site review on 100 percent of the remaining proposed PCP sites within the first six months of operation or expansion.

II. Subsequent Periodic Site Review
MCPs must conduct subsequent site reviews no later than three years after the initial reviews. MCPs may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issues.

MCPs must have a process in place that instructs providers to notify the MCP of a provider site relocation at least 30 days prior to the move so the MCP can conduct a site review on the new location. However, if the provider notifies the MCP after the move:

- The MCP must allow assigned MCP members to continue to see the provider;
- The MCP must not assign new members to the provider until the site review is completed; and
- The MCP must complete the review within 30 days of notification of the move.

Medical Record Review

MCPs review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the patient received care. Incomplete records or lack of documentation implies the MCP's failure to provide care.

MCPs must review ten medical records using the most recent MRR Survey Tool at each provider site as part of the site review and every three years thereafter. During any MRR, reviewers must have the option to request additional records for review. If the MCP reviews additional records, the MCP must calculate the scores accordingly. Preventive care criteria cover pediatric, adult, and obstetric services. The medical record score is based on a survey standard of the ten randomly selected records per provider, consisting of five pediatric and five adult and/or obstetric records. For sites with only pediatric, only adult, or only obstetric patients, all ten records surveyed must be only in that preventive care area.

MCPs must review medical records of a new provider within 90 calendar days of the date the MCP first assigns members to a provider. An MCP may defer that review an additional 90 calendar days only if the new provider does not have enough assigned MCP members to complete a review of the ten medical records. At the end of six months, if the provider still has fewer than ten assigned member records, the MCP must complete an MRR on the total number of records available and adjust the scoring according to the number of records reviewed.

At PCP sites that document patient care performed by multiple PCPs in the same record, the MCP must consider these records a "shared" medical record system. The MCP must consider shared medical records those that are not identifiable as "separate" records belonging to any specific PCP. The MCP must review a minimum of ten records if two or three PCPs share records, 20 records if four to six PCPs share records, and 30 records if seven or more PCPs share records.

Scoring Facility Site Reviews and Medical Record Reviews

MCPs must base their survey scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If an MCP chooses to audit additional criteria not included on the FSR or MRR Survey Tool, the MCP must not add the additional criteria to the existing scoring method. MCPs must not alter scored criteria or assigned weights in any way. Score calculations are based on the total survey points, or on the adjusted survey points for "not applicable" items.

The minimum passing score for the FSR and the MRR is 80 percent of the total points available. A PCP site may earn up to 150 points for a site review with the following compliance level categories:

- Exempted Pass: 90 percent or above, without deficiencies in Critical Elements, Pharmaceutical Services or Infection Control;

- Conditional Pass: 80-89 percent, or 90 percent or above with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control; and
- Not Pass: below 80 percent.

The MRR contains three general categories of Format, Documentation, and Coordination/Continuity of Care and three specific preventive categories of Pediatric Preventive, Adult Preventive, and Obstetrics (OB)/Comprehensive Perinatal Services Program (CPSP).

PCP sites may earn up to 23 points for the three general categories multiplied by the number of medical records reviewed, plus the points given for the preventive services categories, as follows:

- Pediatric Preventive: 19 points multiplied by the number of pediatric medical records reviewed;
- Adult Preventive: 15 points multiplied by the number of adult medical records reviewed; and
- OB/CPSP: 20 points multiplied by the number of OB/CPSP medical records reviewed.

PCP sites may earn a full point if the scored element meets the applicable criteria. MCPs must not award partial points for any scored element that the reviewer considers only "partially" met. PCP sites must earn zero points if an element does not meet the applicable criteria. The reviewer must determine the "not applicable" (N/A) status of each criterion based on a site-specific assessment. The reviewer must explain all criteria scored as zero points or assessed as N/A.

The MRR compliance levels are as follows:

- Exempted Pass: 90 percent or above;
- Conditional Pass: 80-89 percent; and
- Not Pass: below 80 percent.

For detailed scoring procedures, see the FSR Survey Tool and Guidelines (Attachment A) and the MRR Survey Tool and Guidelines (Attachment B).

If a site receives a non-passing score by one MCP, all other MCPs must consider the site as having a non-passing score. MCPs must use the local collaborative process to identify shared providers and to determine their methods for sharing survey information.

Critical Elements

Nine critical elements of the site review define the potential for adverse effects on patient health or safety and have a scored weight of two points. All other survey elements have a scored weight of one point. The PCP site must correct any critical element deficiency identified during a site review, focused survey, or monitoring visit within ten business days of the survey date and the MCP must verify the corrective

actions within 30 calendar days of the survey date. MCPs must ensure that sites that are found deficient in any critical element during a site review correct 100 percent of the survey deficiencies, regardless of the site's survey score. The nine critical elements are the following:

1) Exit doors and aisles are unobstructed and egress (escape) is accessible;
2) Airway management equipment, appropriate to practice and populations served, is present onsite;
3) Only qualified/trained personnel retrieve, prepare or administer medications;
4) Office practice procedures are utilized onsite that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results;
5) Only lawfully authorized persons dispense drugs to patients;
6) Personal protective equipment is readily available for staff use;
7) Needlestick safety precautions are practiced onsite;
8) Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping; and
9) Spore testing of each autoclave/steam sterilizer is completed (at least monthly), with documented results.

Corrective Action Plan

A CAP is required on all cited deficiencies for sites with a Conditional Pass score on the FSR or MRR Survey Tool, on a focused review or for deficiencies identified by the MCP, or State through oversight and monitoring activities. MCPs must require all provider sites that receive a Conditional Pass to develop a CAP to correct 100 percent of cited deficiencies.

MCPs must not require PCP sites that receive an Exempted Pass for FSR to complete a CAP unless the MCP determines that one is needed.

MCPs must not require provider sites that receive an Exempted Pass for an MRR to complete a CAP. A CAP is required for a total MRR score below 90 percent. Also, any section score of less than 80 percent requires a CAP for the entire MRR, regardless of the total MRR score.

MCPs must establish a process for treating providers who pass the site review at 80 percent or higher but fail to respond to a request for a CAP or fail to complete the corrective actions. MCPs must remove a provider from the network regardless of survey scores if criteria are not met or corrective actions are not taken within the established CAP timeline. If removed from the network, providers may file a formal appeal to the MCP.

New provider sites with a score of less than 80 percent are not eligible to participate in the Medi-Cal managed care program. At its discretion, an MCP may decide to provide additional training, give technical assistance or develop a CAP with non-passing pre-contract provider sites. Pre-contract providers who do not pass the survey may correct deficiencies, reapply to the MCP and be resurveyed. If the provider passes, the MCP will follow the procedures outlined for implementing corrective actions for all cited deficiencies.

The MCP conducting the site review is responsible for follow-up, resurvey and closure of the CAP.

The CAP documentation must identify:

- The specific deficiency;
- Corrective actions needed;
- Projected and actual dates of the deficiency correction;
- Reevaluation of timelines and dates; and
- Responsible persons.

The closed CAP must include:

- Documentation of problems in completing corrective actions (if any);
- Training and technical assistance provided by the MCP;
- Evidence of the corrections;
- Completion and closure dates; and
- Name and title of the MCP reviewer.

MCPs must follow the timeline below for CAP notification and completion:

I. Providers with a Conditional-Pass Score

A) At the time of the survey: reviewers must notify providers of non-passing survey scores, critical element deficiencies, other deficiencies determined by the reviewer or MCP to require immediate corrective action and the CAP requirements for these deficiencies.

B) Within ten business days of the survey date:

1) Providers must submit a completed CAP with verification for all critical elements or other survey deficiencies requiring immediate correction to the requesting MCP; and

2) MCPs must provide a survey findings report and a formal written request for corrections of all other deficiencies (i.e., noncritical, non-immediate) to providers.

C) Within 45 days of the survey date, MCPs must reevaluate and verify that PCP sites have corrected critical element deficiencies and other site review deficiencies that require immediate correction.

D) Within 45 calendar days from the date of the written CAP request:

1) Providers must submit a CAP for all deficiencies (other than critical) to the MCP; and

2) MCPs must review, revise or approve the CAP and timelines.

E) Within 90 calendar days from the date of a written CAP request:

1) Providers must complete all other corrective actions; and

2) MCPs must provide educational support and technical assistance as needed, reevaluate or verify corrections and close the CAP.

F) Beyond 90 calendar days of the date of a written CAP request:

1) Providers may request a definitive, time-specific extension period. The period is not to exceed 120 calendar days from the date of the survey findings report and CAP notification, unless a longer extension is approved by DHCS to complete corrections if extenuating circumstances that prevented completion of corrections can be clearly demonstrated and if agreed to by the MCP; and

2) MCPs must resurvey any provider site that required an extension period beyond 120 calendar days to complete corrections prior to closing the CAP in 12 months.

II. Non-Passing Pre-Contract Provider

An MCP must not consider a pre-contract provider who scores below 80 percent as a network provider. The MCP must resurvey the provider before it approves the non-passing provider as a network provider. After the pre-contract provider achieves a score of 80 percent or higher, the MCP must complete the CAP as specified under CAP timeline requirements.

III. Non-Passing Contracted Network Provider

When a network provider receives a non-passing score, the MCP must notify the provider of the score, all cited deficiencies and CAP requirements. MCPs may remove any provider with a non-passing score from their provider networks. However, if an MCP allows a provider with a non-passing score to remain in its provider network, the provider must correct deficiencies and the MCP must verify that the provider has corrected the deficiencies within the CAP timelines established in this policy. MCPs must not assign new members to network providers that score below 80 percent on a subsequent site review until the MCP has verified that the provider has corrected the deficiencies and the CAP is closed.

IV. Noncompliant Provider

MCPs must not assign new members to providers who do not correct survey deficiencies within the established CAP timelines until the MCP verifies that the provider has corrected the deficiencies and the CAP is closed. MCPs must remove

any provider from the network who does not come into compliance with survey criteria within the established timelines, and the MCP must appropriately reassign that provider's MCP patients to other network providers. MCPs must provide affected members with a 30-day notice that it will remove the noncompliant provider from the network.

In addition, provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent in the next site review in both the FSR and MRR (including sites with open CAPs in place). Sites that do not score a minimum of 80 percent in both the FSR and MRR despite the MCP's ongoing monitoring, must be removed from the network and MCP members must be appropriately reassigned to other network providers. MCPs must provide affected members with a 30-day notice that it will remove the noncompliant provider from the network.

V. Provider Appeal Process

Providers removed from an MCP's provider network must have the right to appeal the decision with the MCP. MCPs must have a formal and fair process to resolve grievances and complaints submitted by providers of medical services. If verified evidence of corrections is acceptable to the MCP and the MCP reverses its decision, the MCP must repeat the site review or the MCP may accept the current survey and CAP as completed and resurvey the PCP site in 12 months. If the MCP does not reverse its decision, then the provider may reapply through the MCP's application process. All provider applicants must undergo an initial site review and must be required to adhere to the requirements and standards established by this policy.

Monitoring

MCPs must systematically monitor all PCP sites between each regularly scheduled site review. Monitoring methods may include site reviews, but must also include additional methods such as information gathered through established internal MCP processes and provider and program-specific reports from external sources. When MCPs monitor PCP sites between audits, they must use both internal systems (e.g., quality improvement) and external sources of information (e.g., public health). MCPs must monitor and evaluate the nine critical elements on all PCP sites between site reviews. When MCPs identify problems through monitoring, they must determine the appropriate course of action, such as repeating the site review or conducting additional focused reviews, to investigate and correct these problems in a timely manner.

Focused Review

A focused review is a "targeted" audit of one or more specific areas of the FSR or MRR, and MCPs must not substitute a focused review for a site review. MCPs may use focused reviews to monitor providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may use the appropriate sections of FSR and MRR Survey Tools for the focused review or other methods to investigate identified problems or situations. All deficiencies found

in a focused review must require the completion and verification of corrective actions according to CAP timelines established in this policy.

Local Collaboration

Pursuant to Health and Safety Code Section 1342.8, MCPs must collaborate locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination and consolidation of site audits for mutually shared PCPs. All MCPs within a county have equal responsibility and accountability for participation in the local site review collaborative processes.

MCPs must submit an initial written description and periodic update reports (as requested by DHCS) to DHCS's Medical Monitoring Unit (MMU) describing the local collaboration processes, which include but are not limited to the following:

- Names and titles of participating personnel from each MCP;
- Work plan that includes goals, objectives, activities, and timelines;
- Scheduled meeting dates, times, and locations;
- Meeting processes and outcomes;
- Communication and information-sharing processes;
- Roles and responsibilities of each MCP;
- Delegated activities and use of delegated or subdelegated entities; and
- Memorandum of Agreement requirements established for MCPs and providers.

MCPs must establish policies and procedures to define local collaborative methodology for:

- Confidentiality, disclosure, and release of shared provider survey information;
- Oversight and monitoring of survey processes;
- Site review personnel and training processes;
- Collection and maintenance of a local survey information database system; and
- Evaluation processes.

Review Personnel

Each MCP's Medical Director and Chief Medical Officer are responsible for site review activities implemented by MCP personnel or contracted entities. Each MCP must retain responsibility for oversight of the site review whether the MCP retains its site review functions, delegates site review functions to another MCP or subcontracts site review functions to a third-party entity. MCPs must designate physicians or registered nurses (RN) as certified trainers responsible for training and supervising reviewers, certifying RN and physician reviewers, monitoring reviews and evaluating reviewers for reliability. Certified site review trainers may include personnel from subcontracted agencies.

MCPs must determine the composition of the teams performing site reviews. A variety of personnel may be part of the survey team, including pharmacists, dietitians and

others able to provide assistance and clarification. Each site review must have a certified reviewer (RN or physician) who must sign the FSR and/or MRR.

Reviewers must only examine site review criteria that are appropriate to their level of education, expertise, training, professional licensing and scopes of practice as determined by state law. MCPs must have written policies and procedures that clearly define the duties and responsibilities of all review personnel. MCPs must demonstrate that site review activities established for their reviewers comply with the reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the reviewers' education and training.

Level of Reviewer

Physicians are responsible for the oversight and implementation of peer review determinations regarding the appropriateness of medical care and treatment. However, the California Legislature recognizes the overlapping functions between physicians and RNs and permits the sharing of functions within organized health care systems that provide for collaboration between them (Business and Professions [B&P] Code Section 2725). Activities that overlap the practice of medicine may require adherence to a standardized procedure when it is the RN who determines that they are to be undertaken.

The RN is the minimal level of reviewer acceptable for independently performing the site review. RN reviewers may independently make determinations regarding "direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients and the performance of disease prevention and restorative measures" (Title 16 CCR Section 1443.5). Additionally, RN reviewers may independently make determinations regarding implementation of appropriate reporting or referral of abnormal survey findings to initiate peer review procedures. An RN may only delegate tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the tasks the RN would delegate.

Licensed vocational nurses (LVN) must not be employed as independent practitioners. LVNs are described by the California Board of Licensed Vocational Nursing and Psychiatric Technicians as "dependent" practitioners and "entry-level health care providers responsible for rendering basic bedside nursing care under the direction of a physician or registered nurse." State law stipulates that the LVN must perform only manual skills under the direction of a licensed physician or licensed professional nurse and perform only basic data collection (B&P Code Section 2859). The performance of manual skills or basic data collection does not include evaluation, analysis, interpretation, or synthesis of survey information or data or of making determinations about the information or data that was collected. Although an LVN may collect basic explicitly defined data, he or she is not qualified to evaluate or analyze the data. Therefore, LVN reviewers must not independently review any facility site or medical record, but, as part of a survey team, may collect data on those survey elements that

DHCS and the California Board of Vocational Nursing and Psychiatric Technicians have identified as within the LVN scope of practice. Non-licensed, nonregistered, noncertified personnel and dependent licensed medical personnel may be members of a site review team as appropriate, but must not be employed as independent site reviewers.

Site Review Training and Certification

MCPs are responsible for ensuring that all reviewers conducting FSRs and MRRs are appropriately trained, monitored and evaluated. MCPs may collaborate to determine local systems for training and certifying reviewers. Training must include MMCD seminars, and may also include MCP classes, individual or small group training sessions provided by a certified site review trainer and self-study learning programs. MCPs must certify site review trainers and certify physicians and RNs as site reviewers and recertify them every three years thereafter.

Site Review Data Submission Procedures

MCPs must submit site review data to MMU's nurse evaluators every six months (due July 31 for the period January through June, and due January 31 for the period July through December). MCPs may submit data at their discretion more frequently than every six months. For preoperational and expansion site reviews, MCPs must submit site review data to MMU's nurse evaluators at least six weeks prior to site operation. MCPs must submit data in an approved Microsoft Excel format uploaded to a designated DHCS secure site. MMU will make available through its site review web portal an Excel database containing all necessary tables and data input forms for the mandatory biannual submission of FSR and MRR data. DHCS will reject site review data that MCPs submit in nonconforming formats.

Department of Health Care Services/Medi-Cal Managed Care Health Plan Responsibility

DHCS must collaborate with MCPs to develop, implement and evaluate site review training and certification, revise training curriculum and materials as needed and provide technical assistance to site review trainers. The training curriculum includes self-learning modules, lesson plans for didactic instruction and guidelines for trainer and reviewer certification.

DHCS must oversee and monitor MCPs for implementation of the site review policy. Monitoring areas may include, but are not limited to, oversight of MCP methods for monitoring provider sites between site reviews, use of the appropriate level of reviewer according to established scope of practice legislation and the standards outlined in this policy and local collaborative processes. Monitoring methods may include, but are not limited to, participating in local collaborative processes, observing reviewer training and certification processes, assessing data collection methods and evaluating aggregate reports.

As part of the DHCS's ongoing monitoring process, DHCS nurses conduct separate onsite site reviews of randomly chosen PCP sites to validate FSR and MRR processes

and to monitor MCP services. DHCS will provide MCPs with a written report of the DHCS-conducted review.

An MCP must, within 30 days from the report date of the DHCS-conducted site review, provide a CAP to DHCS responding to all cited deficiencies documented in the report. The MCP's CAP response must include:

- The deficiency;
- A description of action(s) taken to correct the deficiency; and
- The result of the action(s) taken.

If a deficiency is determined to require long-term corrective action, the MCP's CAP response must additionally include indication the MCP has:

- Initiated remedial action;
- Developed a plan to achieve an acceptable level of compliance; and
- Documented the date the provider is in full compliance or when full compliance will be achieved.

Additional supporting documentation and remedial action may be required if DHCS determines the CAP is insufficient to correct a deficiency.

When DHCS conducts a site review, DHCS notifies the affected MCP in advance. Each MCP must notify its providers in advance of site reviews whether the site review is conducted by DHCS or by the MCP. However, inspection of an MCP's facilities or other elements of a survey may be conducted **without prior notice**, in conjunction with the medical survey or as part of an unannounced inspection program (Title 28 CCR Section 1300.80).

If you have questions regarding this PL, please contact your assigned MMU nurse.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments

Site Review Guidelines

California Department of Health Care Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

1) Exempted Pass: 90% or above *without deficiencies* in Critical Elements, Pharmaceutical or Infection Control
2) Conditional Pass: 80-89%, or 90% and above with deficiencies in either Critical Elements, Pharmaceutical or Infection Control
3) Not Pass: below 80%

A corrective action plan (CAP) is required for a total score less than 90%, *OR* for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. Compliance rates are based on 150 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled ☐☐**RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all six (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from 150 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 150 points.
4) Divide the total points given by 150 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.

Step 2: Add points given for all six (6) sections.

Example:
25 (Access/safety)
22 (Personnel)
23 (Office Management)
34 (Clinical Services)
11 (Preventive Services)
25 (Infection Control)
140 (POINTS)

Step 3: Subtract "N/A" points from 150 total points possible.

150 (Total points possible)
– 5 (N/A points)
145 ("Adjusted" total points possible)

Step 4: Divide total points given by 150 or by the "adjusted" points, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Points given}}{\text{150 or "adjusted" total}} \quad \text{or} \quad \frac{140}{145} = 0.97 \times 100 = \mathbf{97\%}$$

Criteria	I. Access/Safety Reviewer Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	• **ADA Regulations**: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). • **Parking**: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. • **Ramps**: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. • **Exit doors**: The width of exit doorways (at least 32-in. or reasonable accommodation) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. • **Elevators**: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat and clean. • **Clear Floor Space**: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. • **Sanitary Facilities**: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows for wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. **Note:** A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

Criteria	I. Access/Safety Reviewer Guidelines
B. Site environment is maintained in a clean and sanitary condition.	The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition.
C. Site environment is safe for all patients, visitors and personnel.	• **Ordinances**: Sites must meet city, county and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. • **Non-medical emergency procedures:** Non-medical emergencies include incidents of fire, natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for handling fire emergencies and evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. • **Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. • **Illumination**: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. • **Access Aisle**: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas. • **Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. • **Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. • **Fire Fighting/Protection Equipment**: There is fire fighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder or other assistive devices. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries. 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances. 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. **Note: Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

RN/MD Review only

Criteria	I. Access/Safety Reviewer Guidelines
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	• **Site Specific Emergency procedures**: Staff is able to describe site-specific actions or procedures for handling medical emergencies until the individual is stable or under care of local emergency medical services (EMS). There is a written procedure for providing immediate emergent medical care on site until the local EMS is on the scene. Although site proximity to emergency care facilities may be considered when evaluating medical emergency procedures, the key factor is the ability to provide immediate care to patients *on site* until the patient is stable or EMS has taken over care/treatment. When the MD or NPMP is not onsite, staff/MA may call 911, and CPR-certified staff may initiate CPR if needed. Non-CPR-certified staff may only call 911 and stay with the patient until help arrives. • **Emergency medical equipment**: During business hours providers are prepared to provide emergency services for management of emergency medical conditions that occur on site ***until*** the emergent situation is stabilized and/or treatment is initiated by the local 911 Emergency Medical Service (EMS) system. Minimum emergency equipment is available on site to: 1) establish and maintain a patent/open airway, and 2) manage anaphylactic reaction. Emergency equipment and medication, appropriate to patient population, are available in an accessible location. An accessible location is one that is reachable by personnel standing on the floor, or other permanent working area, without locating/retrieving step stool, ladder or other assistive devices. For emergency "Crash" cart/kit, contents are appropriately sealed and are within the expiration dates posted on label/seal. Site personnel are appropriately trained and can demonstrate knowledge and correct use of all medical equipment they are expected to operate within their scope of work. Documented evidence that emergency equipment is checked at least monthly may include a log, checklist or other appropriate method(s). • **Emergency phone number list**: Posted list includes local emergency response services (e.g., fire, police/sheriff, ambulance), emergency contacts (e.g., responsible managers, supervisors), and appropriate State, County, City and local agencies (e.g., local poison control number). The list should be dated, and updated annually. • **Airway management**: Without the ability to adequately maintain the patient's airway, all other interventions are futile. Minimum airway control equipment includes a wall oxygen delivery system or portable oxygen tank, oropharyngeal airways, nasal cannula or mask, and Ambu Bag. Various sizes of airway devices appropriate to patient population within the practice are on site. Portable oxygen tanks are maintained at least ¾ full. There is a method/system in place for oxygen tank replacement. If oxygen tanks are less than ¾ full at time of site visit, site has a back-up method for supplying oxygen if needed ***and*** a scheduled plan for tank replacement. Oxygen tubing need not be connected to oxygen tank, but must be kept in close proximity to tank. Health care personnel at the site must demonstrate that they can turn on the oxygen tank**.** • **Anaphylactic reaction management**: Severe allergic reaction can cause urticaria (hives), hypotension, bronchospasm, wheezing and pulmonary edema. Minimum equipment includes Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg/ml (injectable), appropriate sizes of ESIP needles/syringes*and alcohol wipes. (*If the emergency kit or "crash cart" has only non-safety needles/syringes, score that deficiency in Section VI., Infection Control, criteria B.2. See Infection Control guidelines). There is a current medication administration reference (e.g. medication dosage chart) available for readily identifying the correct medication dosages (e.g. adult, pediatric, infant, etc.). Package inserts are not acceptable as dosage charts. **Note:** An "emergency medical condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the health of the individual (or unborn child of a pregnant woman) in serious jeopardy, 2) serious impairment to bodily functions, and 3) serious dysfunction of any bodily organ or part. "Emergency services" means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

RN/MD Review only

Criteria	I. Access/Safety Reviewer Guidelines
E. Medical and lab equipment used for patient care is properly maintained.	• **Medical and laboratory equipment**: All equipment used to measure or assess patient health status/condition is clean. • **Documentation**: There is documented evidence that standard operating procedures have been followed for routine inspection/ maintenance, calibration, repair of failure or malfunction, and testing and cleaning of all specialized equipment. Appropriate written records include calibration or other written logs, work orders, service receipts, dated inspection sticker, etc. All equipment used to measure or assess patient health status/condition is functioning properly. All specialized equipment (e.g., ultrasonography equipment, electrocardiogram (EKG) machine, defibrillator, audiometer, hemoglobin meter, glucometer, scales, etc.) are adequately maintained according to the specified manufacturer's guidelines for the equipment, or is serviced annually by a qualified technician. Blood pressure cuffs, monitors, and other related equipment need not be calibrated unless required by the manufacturer. Manufacturer guidelines must be available on site, indicating that it is not necessary to calibrate the equipment. Note: The term monitor includes, but not limited to, glucometers, EKG, BP monitors, hemacues, and audiometers.

<table>
<tr><th>Criteria</th><th colspan="3">II. Personnel Reviewer Guidelines</th></tr>
<tr><td rowspan="12">A. Professional health care personnel have current California licenses and certifications.</td><td>Medical Professional</td><td>License/Certification</td><td>Issuing Agency</td></tr>
<tr><td>Certified Nurse Midwife (CNM)</td><td>RN License & Nurse-Midwife Certificate.
DEA Registration, if appropriate</td><td>CA Board of Registered Nursing
Drug Enforcement Administration (DEA)</td></tr>
<tr><td>Certified Radiological Technologist (CRT)</td><td>CRT Certificate.</td><td>CDPH, Radiologic Health Branch</td></tr>
<tr><td>Doctor of Osteopathy (DO)</td><td>Physician’s & Surgeon’s Certificate.
DEA Registration</td><td>Osteopathic Medical Board of CA
DEA</td></tr>
<tr><td>Licensed Vocational Nurse (LVN):</td><td>LVN License.</td><td>CA Board of Vocational Nursing and
Psychiatric Technicians</td></tr>
<tr><td>Nurse Practitioner (NP)</td><td>RN License w/NP Certification & Furnishing
Number. DEA Registration, if appropriate</td><td>CA Board of Registered Nursing
DEA</td></tr>
<tr><td>Pharmacist (Pharm. D)</td><td>Pharmacist License</td><td>CA State Board of Pharmacy</td></tr>
<tr><td>Physician/Surgeon (MD)</td><td>Physician’s & Surgeon’s Certificate.
DEA Registration</td><td>Medical Board of CA
DEA</td></tr>
<tr><td>Physicians’ Assistant (PA)</td><td>PA License.
DEA Registration, if appropriate</td><td>Physician Assistant Examining
Committee/Medical Board of CA, DEA</td></tr>
<tr><td>Radiological Technician</td><td>Limited Permit.</td><td>CDPH, Radiologic Health Branch</td></tr>
<tr><td>Registered Dietitian (RD)</td><td>RD Registration Card.</td><td>Commission on Dietetic Registration</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License.</td><td>CA Board of Registered Nursing</td></tr>
<tr><td colspan="3"><u>Note:</u> All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California, and available on site. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.</td></tr>
<tr><td colspan="3">
<table>
<tr>
<td><u>Note:</u> Effective June 27, 2010, per CCR, Title 16, 1355.4, mandated by Business and Professions Code section 138, MDs (does not apply to Osteopaths) shall provide notification to each patient that states the MD(s) on site is licensed and regulated by the Board, and includes the following:

NOTICE
Medical doctors are licensed and regulated
by the Medical Board of California (800)
633-2322
<u>www.mbc.ca.gov</u>.</td>
<td><u>Note:</u> Effective August 11, 2011, per CCR, Title 16, 1399.547, mandated by Business and Professions Code section 138, PAs shall provide notification to each patient that states the PA(s) is licensed and regulated by the Physician Assistant Committee, and includes the following:

NOTIFICATION TO CONSUMERS Physician
Assistants are licensed and regulated by the
Physician Assistant Committee
(916) 561-8780
<u>www.pac.ca.gov</u></td>
</tr>
</table>
The notice to consumers above shall be provided by one of the following methods: 1) prominently posted sign in an area visible to patients in at least 48-pt Arial font, 2) a written statement signed and dated by the patient (or patient’s representative) and kept in the medical record, stating the patient understands that the MD is licensed and licensed and regulated by the board (for PA’s, that the PA is licensed and regulated by the PA Committee), or 3) a statement on letterhead, discharge instructions or other document given to the patient (or patient’s representative), where the notification is placed immediately above the signature line for the patient in a at least 14-pt font.
</td></tr>
<tr><td>B. Health care personnel are properly identified.</td><td colspan="3">Health care personnel shall disclose, while working, their name and title on a name tag at least 18-point type. It is acceptable for health care personnel in a practice or an office, whose license is prominently displayed, to opt not to wear a nametag. In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title “nurse” in reference to himself or herself, in any capacity, except for an individual who is a registered nurse, or a licensed vocational nurse. <u>Note:</u> “Health care practitioner” means any person who engages in acts that are the subject of licensure or regulation under the CA B&P Code (Section 680-681). If a health care practitioner or licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for the individual safety or therapeutic concerns.</td></tr>
</table>

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
C. Site personnel are qualified and trained for assigned responsibilities.	• **Medical equipment:** Provider and/or staff are able to demonstrate appropriate operation of medical equipment used in their scope of work. Not all staff is required to be proficient in use of all equipment. • **Unlicensed personnel**: Medical assistants (MA) are unlicensed health personnel, at least 18 years of age, who perform basic administrative, clerical, and non-invasive routine technical supportive services under the supervision of a licensed physician, surgeon or podiatrist in a medical office or clinic setting. Supervision means the licensed physician must be physically present in the treatment facility during the performance of authorized procedures by the MA. Training may be administered under a licensed physician; or under a RN, LVN, PA, or other qualified medical assistant acting under the direction of a licensed physician. The supervising physician is responsible for determining the training content and ascertaining proficiency of the MA. Training documentation maintained on site for the MA must include the following: A) Diploma or certification from an accredited training program/school, ***or*** B) Letter/statement from the current supervising physician that certifies in writing: date, location, content, and duration of training, demonstrated proficiency to perform current assigned scope of work, and signature. • **Medications**: Unlicensed staff (e.g. medical assistants) has evidence of appropriate training and supervision in all medication administration methods performed within their scope of work. Medication administration by a MA means the direct application of pre-measured medication orally, sublingually, topically, vaginally or rectally; or by providing a single dose to a patient for immediate self-administration by inhalation or by simple injection. **All medications including vaccines must be verified with (shown to) a licensed person prior to administration.** To administer medications by subcutaneous or intramuscular injection, or to perform intradermal skin tests or venipunctures for withdrawing blood, an MA must have completed at least the minimum number of training-hours established in CCR, Title 16, Section 1366.1. **MAs cannot administer anesthetics, including local anesthetic agents (such as Rocephin hydrated with Xylocaine).** Medical assistants may not place an intravenous needle, start or disconnect the intravenous infusion tube, administer medications or injections into an intravenous line, or administer anesthesia. The supervising physician must specifically authorize all medications administered by an MA. Authorization means a specific written or standing order prepared by the supervising physician. **Note:** Personnel on site must be qualified for their responsibilities and adequately trained for their scope of work. Site staff should have a general understanding of the systems/processes in place, appropriate supervision and knowledge of the available sources of information on site.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined.	Reviewers are expected to verify that NP and/or CNM standardized procedures, and PA Delegation of Services Agreement and Supervision Physician's Responsibility documentation are present on site. Reviewers are ***not*** expected to make in-depth evaluation of "appropriateness" of the NPMP's scope of practice. Documents may be utilized to determine and/or clarify practice procedures and supervisory processes on site. • **Certified Nurse Midwives** (CNM): The certificate to practice nurse-midwifery authorizes the holder, under supervision of a licensed physician or surgeon, to attend cases of normal child-birth and to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother, and immediate care for the newborn. The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has delivery privileges. • **Nurse Practitioners** (NP): Nurse practitioners are prepared through education and experience to provide primary care and to perform advanced procedures. The extent of required supervision must be specified in the Standardized Procedures. • **Physician Assistants** (PA): Every PA is required to have the following documents: 1) Delegation of Services Agreement: Defines specific procedures identified in practice protocols or specifically authorized by the supervising physician, and must be dated and signed by physician and PA. An original or copy must be readily accessible at all practice sites in which the PA works. There is no established time period for renewing the Agreement, but it is expected that the Agreement will be revised, dated and signed whenever any changes occur. Failure to maintain a Delegation of Services Agreement is a violation of the Physician Assistant Regulations and is grounds for disciplinary action by the Medical Board of California against a physician assistant's licensure. 2) Approved Supervising Physician's Responsibility for Supervision of Physician Assistants Agreement: Defines supervision responsibilities and methods required by Title 16, section 1399.545 of the Physician Assistant Regulations, and is signed by the physician. The following procedures must be identified: a) Transport and back-up procedures for when the supervising physician is not on the premises. b) One or more methods for performing medical record review by the supervising physician: c) Responsibility for physician review and countersigning of medical records d) Responsibility of the PA to enter the name of approved supervising physician responsible for the patient on the medical record. • **Drug Enforcement Agency** (DEA): Each NP, CNM, and PA that prescribes controlled substances is required to have a valid DEA Registration Number. **Note:** Standardized procedures legally define the expanded scope of nursing practice that overlaps the practice of medicine. CNMs and NPs operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the NP and administration within the organized health care facility/system in which standardized procedures will be used. Standardized Procedures should identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures. Standardized Procedures shall undergo periodic review, with signed, dated revisions completed at each change in scope of work.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
E. Non-physician medical practitioners (NPMP) are supervised according to established standards.	• **Non-physician medical practitioners**: The Supervising Physician holds ultimate responsibility for the practice of each supervised non-physician medical practitioner. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following: 4 nurse practitioners, 3 nurse midwives, 4 physician's assistants, or 4 of the above individuals in any combination which does not exceed the limit stated. This ratio is based on each physician, not the number of offices. A primary care physician, an organized outpatient clinic or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits. Ref: Assembly Bill 3 Bass, Chapter 376, October 2007, effective January 1, 2008, allows 4 PAs to 1 MD; Business & Professions Code 3516(b); W & I Code 14132.966. Physician Assistant Committee is at: http://www.pac.ca.gov/ or the PAC office at 916-561-8780. • **Supervising physician**: "Supervising physician" means a physician and/or surgeon licensed by the Medical Board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, possesses a current valid license to practice medicine, and is not currently on disciplinary probation for improper use of a physician assistant. "Supervision" means that a licensed physician and surgeon oversee the activities of, and accept responsibility for, the medical services rendered by a physician assistant. Physicians must comply with all current and/or revised requirements established by the Medical Board of CA for supervising physician assistants.

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
F. Site personnel receive safety training/information.	• **Bloodborne Pathogens**: Site personnel treat all blood and other potentially infectious materials (OPIM) as if these *are* infectious. Site personnel who are reasonably anticipated to have eye, skin, mucous membranes and potential exposure to blood and/or other potentially infectious materials (OPIM) receive training as required by the Bloodborne Pathogens Standard, Title 8, CCR, Section 5193. Training occurs ***prior to*** initial exposure to potentially infectious and/or biohazardous materials. Review and re-training sessions occur ***at least annually***. Training content is appropriate (language, educational level, etc.) to personnel on site. Training *minimally* includes the following: ‣ universal/standard precautions ‣ use of personal protective equipment ‣ accessible copy of Bloodborne Pathogens Standard ‣ work practice controls/exposure prevention ‣ modes of transmitting bloodborne pathogens ‣ epidemiology/symptoms of HBV and HIV ‣ recognition of activities with exposure element ‣ handling and labeling of biohazardous waste(s) ‣ Hepatitis B vaccination protocol and requirements ‣ explanation of emergency procedures ‣ post exposure reporting/evaluation/follow-up procedures ‣ decontamination of equipment/work areas ‣ site's written bloodborne pathogen exposure plan ‣ opportunity for discussion/questions Personnel must know ***where to locate*** information/resources on site about infection control, the Bloodborne Pathogens Exposure Plan, and ***how to use*** the information. Evidence of training must be verifiable. Evidence of training may include informal in-services, new staff orientation, external training courses, educational curriculum and participation lists, etc. Training documentation must contain the employee's name, job titles, training date(s), type of training, contents of training session, and names/qualifications of trainers. Records must be kept for three (3) years. • **Abuse Reporting**: Site personnel have specific knowledge of local reporting requirements, agencies, and procedures, and know *where to locat*e information on site and *how to use* information. **Note:** Health practitioners (e.g., physicians, surgeons, licensed nurses, licensed social workers, paramedics) in a health facility, (e.g., clinic, physician's office, public health clinic) are legally mandated reporters of known or reasonably suspected cases of child abuse, elder abuse and domestic violence. Legally mandated reporters must make telephone and written reports according to timeliness standards established by the designated local law enforcement agencies in each county. "Reasonably suspects" means having objectively reasonable suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect abuse (CA Penal Code 11164). Failure to report by legally mandated reporters can result in criminal or civil prosecutions, punishable by monetary fines and/or county jail confinement. Any person entering employment which makes him/her a mandated reporter must sign a statement, provided and retained by the employer, that the employee has knowledge of the Child Abuse reporting law and will comply with its provision (CA Penal Code 11166.5).

RN/MD Review only

Criteria	II. Personnel Reviewer Guidelines
G. Site personnel receive training and/or information on member rights.	Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.

RN/MD Review only (#B)

Criteria	III. Office Management Reviewer Guidelines
A. Physician coverage is available 24 hours a day, 7 days a week.	Current clinic office hours are posted within the office or readily available upon request. Current site-specific resource information is available to site personnel about physician office hour schedule(s), local and/or Plan-specific systems for after-hours urgent care, emergent physician coverage available 24 hours a day, 7 days per week, and system for providing follow-up care. When a physician is not on site during regular office hours, personnel are able to contact the physician (or covering physician) at all times by telephone, cell phone, pager, etc. **Note:** One objective of effective clinic office management is to support the provision of appropriate, coordinated health care services. The review of clinic office management is to evaluate if effective systems are in place and whether site personnel appropriately follow established site-specific procedures.
B. There is sufficient health care personnel to provide timely, appropriate health care services.	In addition to the physician, only appropriately licensed medical personnel such as a CNM, NP, RN, or PA handles emergency, urgent, and medical advice/triage telephone calls. The California Board of Vocational Nursing and Psychiatric Technician Examiners has determined that the Licensed Vocational Nurse Practice Act ***does not*** permit the LVN to perform triage independently (MCPB Letter 92-15). The LVN may perform that part of the triage process that includes observation and data collection relative to basic physical assessment. The LVN ***may not*** perform that part of the triage process that includes independent evaluation, interpretation of data, and determination of treatment priorities and levels of care. Unlicensed personnel, such as medical assistants, may provide patient information or instructions only as authorized by the physician (Title 16, §1366 (b)). **Note:** Telephone triage is the system for managing telephone callers during ***and*** after office hours.

RN/MD Review only (#C)

Criteria	III. Office Management Reviewer Guidelines
C. Health care services are readily available.	The process established on site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult initial health assessments, specialty care and emergency care. An organized system must be clearly evident (in use) for scheduling appointments appropriately, notifying and reminding members of scheduled appointments, and following up of missed or canceled appointments. Systems, practices and procedures used for making services readily available to patients will vary from site to site. Missed and/or canceled appointments, and contact attempts must be documented in the patient's medical record. **Note:** Medi-Cal Managed Care Health Plans *require* the following timeliness standards for access to appointments: • Urgent Care: 48 hours • Access to the first Prenatal Visit: 10 business days • Non-urgent (Routine) Care: 10 business days
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. A family member or friend may be used as an interpreter if requested by the LEP individual after being informed of their right to use free interpreter services. **Note:** Assessment of interpreter skills may include written or oral assessment of bilingual skills, documentation of the number of years of employment as an interpreter or translator, documentation of successful completion of a specific type of interpreter training programs (medical, legal, court, semi-technical, etc.), and/or other reasonable alternative documentation of interpreter capability. A request for or refusal of language/ interpreter services must be documented in the member's medical record.

RN/MD Review only (#E)

Criteria	III. Office Management Reviewer Guidelines
E. Procedures for timely referral/ consultative services are established on site.	An organized, timely referral system is clearly evident for making and tracking referrals, reviewing reports, providing/scheduling follow-up care and filing reports in medical records. Referral informational resources are readily available for use by site personnel. Site staff can demonstrate (e.g., "walk through") the office referral process from beginning to end. Systems, practices and procedures used for handling referrals will vary from site to site.
F. Member grievance/ complaint processes are established on site.	At least one telephone number for filing grievances is posted on site, or is readily available upon request. Complaint forms and a copy of the grievance procedure are readily available on site, and can be provided to members promptly upon request. **Note:** A "grievance" is defined as any written or oral expression of dissatisfaction and shall include any complaint, dispute, request for reconsideration or appeal made by an enrollee or their representative to a Plan or entity with delegated authority to resolve grievances on behalf of the Plan.

RN/MD Review only (#H)

Criteria	III. Office Management Reviewer Guidelines
G. Medical records are available for the practitioner at each scheduled patient encounter.	The process/system established on site provides for the availability of medical records (paper and electronic), including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055).
H. Confidentiality of personal medical information is protected according to State and federal guidelines.	• **Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. • **Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed or left unattended in reception and/or patient flow areas. • **Electronic records**: Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files. • **Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. • **Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology and psychiatric clinics must maintain medical records and exposed x-rays for a minimum of 7 years following patient discharge, except for minors (Title 22, CCR, Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 18, but in no event for less than **7** years (Title 22, CCR, Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53861).

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Controlled substances**: Written records are maintained of controlled substances inventory list(s) that includes: provider's DEA number, name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11058, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, physician's assistants, licensed nurses and pharmacists. • **Security**: All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4172). Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 13, Section 1356.3). The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs. The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. **Note**: During business hours, the drawer, cabinet or room containing drugs, medication supplies or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area ***at all times***. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times.

RN/MD Review only

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
B. Drugs are handled safely and stored appropriately.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Drug preparation**: A drug or device is considered "adulterated" if it contains any filthy, putrid, or decomposed substance, or if it has been prepared, packed or held under unsanitary conditions (21 USC, Section 351). A drug is considered contaminated if it has been held under unsanitary conditions that may have been contaminated with filth, or rendered injurious to health. • **Storage**: Medications are kept separate from food, lab specimens, cleaning supplies, and other items that may potentially cause contamination. Drugs are stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product are not affected (21 CFR, Section 211.142). Room temperature where drugs are stored does not exceed 30ºC (86ºF) (Title 22, Section 75037 (d)). • **Immunobiologics**: Vaccines are refrigerated immediately upon receipt on site and stored according to specific instructions on the package insert for each vaccine. Diluent does not need refrigeration if vaccine is administered right after diluent is added. Vaccines are not stored in the doors of refrigerator or freezer. Refrigerator and freezer temperatures are documented at least once a day. Site personnel must be able to verbalize the procedure used to promptly respond to OUT OF RANGE TEMPERATURES. Contacting VFC or manufacturer are acceptable procedures. Refrigerator: Vaccines are kept in a refrigerator **maintained at 2-8ºC or 35-46ºF,** and include, but are not limited to, DTaP, Td, Tdap, Hepatitis A, Hepatitis B, IPV, Pneumococcal, Rotavirus, Hib, Influenza (inactivated and FluMist), MCV, HPV, Zoster, or any combinations of these listed vaccines. Freezer: Varicella and MMRV vaccines are stored in the **freezer at -15ºC or 5ºF, or lower,** and are protected from light at all times. MMR may be stored in a refrigerator or freezer; VFC recommends MMR be stored in the freezer with MMRV. If vaccines are in solid state and contain ice crystals on the outside of vial, they are considered appropriately frozen. • **Hazardous substances labeling**: Safety practices are followed in accordance with current/updated CAL-OSHA standards. The manufacturer's label is not removed from a container (bag, bottle, box, can, cylinder, etc.) as long as the hazardous material or residues of the material remain in the container. All portable containers of hazardous chemicals and secondary containers into which hazardous substances are transferred or prepared require labeling. Labels must provide the following information: 1) identity of hazardous substance, 2) description of hazard warning: can be words, pictures, symbols 3) date of preparation or transfer. • **Exception**: Labeling is not required for portable containers into which hazardous chemicals are transferred from labeled containers, and which are intended only for the immediate use of the individual who performs the transfer. **Note:** The purpose of hazard communication is to convey information about hazardous substances used in the work place. A hazardous substance is any substance that is a physical or health hazard. Examples of a physical hazard include substances that are a combustible liquid, a compressed gas, explosive, flammable, an organic peroxide, an oxidizer, pyrophoric, unstable (reactive) or water-reactive. Examples of a health hazard include substances where acute or chronic health effects may occur with exposure, such as carcinogens, toxic or highly toxic agents, irritants, corrosives, sensitizers and agents that damage the lungs, skin, eyes, or mucous membranes.

Criteria	IV. Clinical Services - Pharmaceutical Reviewer Guidelines
C. Drugs are dispensed according to State and federal drug distribution laws and regulations.	• **Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. • **Expiration date**: The manufacturer's expiration date must appear on the labeling of all drugs. All prescription drugs not bearing the expiration date are deemed to have expired. If a drug is to be reconstituted at the time of dispensing, its labeling must contain expiration information for both the reconstituted and unconstituted drug. Expired drugs may not be distributed or dispensed. • **Prescription labeling**: Each prescription medication dispensed is in a container that is not cracked, soiled or without secure closures (Title 22, CCR, Section 75037 (a)). Drug container is labeled with the provider's name, patient's name, drug name, dose, frequency, route, quantity dispensed, and manufacturer's name and lot number. California Pharmacy Law *does not* prohibit furnishing a limited quantity of sample drugs if dispensed to the patient in the package provided by the manufacturer, no charge is made to the patient, and appropriate documentation is made in the patient's medical record (CA Business and Professions Code, Sections 4170, 4171). • **Drug distribution**: Each clinic that provides drug distribution services has written policies and procedures for the safe and effective distribution control, storage, use and disposition of drugs. • **Drug dispensing**: Drug dispensing is in compliance with all applicable State and federal laws and regulations. Drugs are dispensed only by a physician, pharmacist or other persons (e.g., NP, CNM, RN, PA) lawfully authorized to dispense medications upon the order of a licensed physician or surgeon. Personnel such as medical assistants, office managers, and receptionists do not dispense drugs. Drugs are not offered for sale, charged or billed to Medi-Cal members (Business and Professions Code, Article 13, Section 4193). A record of all drugs dispensed is entered in the patient's medical record. • **Vaccine Immunization Statements** (VIS): Since 1994, the National Childhood Vaccine Injury Act, Section 2126 of the Public Health Service Act, mandates that parents/guardians or adult patients be informed before vaccinations are administered. Health care providers must present and offer a copy of the most recent VIS to patients prior to any vaccine.* The date the VIS was given (or presented and offered) *and* the publication date of the VIS must be documented in the patient's medical record. The most current VIS are available from state and local health departments or can be downloaded from the CDC web site at http://www.cdc.gov/vaccines/pubs/vis/default.htm or by calling the CDC Immunization Hotline at (800) 232-2522. The Vaccines for Children (VFC) also contains current VIS and provider notifications at http://www.eziz.org/. *VIS published by CDC is to be provided to the patient/parent/guardian prior to administration of that vaccination. (42USC, 300aa-26(D)(2)). As of 2009, CDC allows providers to present a copy of the current VIS (such as a laminated copy in a binder, etc.) to the patient/parent/guardian and allow time for the patient to read and ask questions. Staff should also *offer* a copy each time (www.cdc.gov/vaccines/pubs/vis/vis-facts.htm). • **Pharmacy**: If a pharmacy is located on site, a licensed pharmacist monitors drug distribution and policies/procedures for medication dispensing/storage. **Note:** "Dispensing" of drugs means the furnishing of drugs or devices directly to a patient or upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant or pharmacist acting within the scope of his or her practice.

Criteria	IV. Clinical Services – Laboratory Reviewer Guidelines
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.	• **CLIA Certificates**: All sites that perform laboratory testing for human health assessment, diagnosis, prevention, or treatment of disease has a current, unrevoked, unsuspended site-specific Clinical Laboratory Improvement Amendment (CLIA) certificate, or evidence of renewal. Acceptable documentation such as the original certificate, copy of the original certificate, renewal receipt or other evidence of renewal submission is present on site or readily available upon request. The CLIA certificate or evidence of renewal should include the current site/clinic address. Note: Per 42 CFR, 493.35(b)(1-3), 493.43(b)(1-3) and 493.55(b)(1-3), laboratories must file a separate application for each laboratory location, with the following *exceptions*: 1) Laboratories that are not at a fixed location, that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations may be covered under the certificate of the designated primary site or home base, using its address, 2) Not-for-profit or Federal, State, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests per certificate) public health testing may file a single application, or 3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction may file a single application or multiple applications for laboratory sites within same physical location or street address. The CLIA Certificate on site includes one of the following: A) Certificate of Waiver: Site is able to perform only exempt waived tests. B) Certificate for Provider-Performed Microscopy (PPM): Physicians, dentists, or mid-level practitioners are able to perform PPM procedures and waived tests. C) Certificate of Registration: Allows moderate and/or high complexity lab testing to be conducted until compliance with CLIA regulations are determined by survey. D) Certificate of Compliance: Lab has been surveyed and found in compliance with all applicable CLIA requirements. E) Certificate of Accreditation: Lab is accredited by an accreditation organization approved by the Centers for Medicare & Medicaid Services (CMS). • **Waived tests**: If only waived tests are performed, site has a current CLIA Certificate of Waiver. There are no specific CLIA regulations regarding the performance of waived tests. Site personnel are expected to follow the test manufacturer's instructions. Laboratories with certificates of waiver may not be routinely inspected by DHCS Laboratory Field Services Division, but may be inspected as part of complaint investigations and on a random basis to determine whether only waived tests are being performed. • **Moderate and High complexity tests**: Tests not listed as waived are divided into one of two categories, moderate complexity or high complexity, based on the complexity of the testing procedure. CLIA regulations for these categories list specific requirements for laboratory proficiency testing, patient test management, quality control, quality assurance, personnel, and inspections. • **Personnel training:** Prior to testing biological specimens, personnel have been appropriately trained for the type and complexity of the laboratory services performed. Personnel have demonstrated the ability to perform all testing operations reliably and to report results accurately. Site personnel that perform CLIA waived tests have access to and are able to follow test manufacturer's instructions. When requested, site personnel are able to provide a step-by-step verbal explanation or demonstration of test procedure and how to determine test results. The required training and certification is established by legislation (CA B&P Codes, §1200-1213) for personnel performing moderate and high complexity tests. Reviewers are not expected to complete an in-depth evaluation of personnel performing moderate and high complexity tests. **Note:** Any site that performs tests or examinations on human biological specimens derived from the human body is, by definition, "laboratories" under State and federal law, and includes locations such as nurses' stations within hospitals, clinics, surgical centers, physician offices, and health fairs. The current listing of waived tests may be obtained at www.fda.gov/cdrh/clia/testswaived.html. CLIA re/certification includes an evaluation every two years (or sooner of complaint driven) by CDPH of personnel licenses/training, laboratory site inspection and demonstration of testing proficiency for moderate and high-complexity test sites. **Contact CDPH Laboratory Field Services (510) 620-3800 for CLIA certification, laboratory license, or personnel questions.**

Criteria	IV. Clinical Services - Radiology Reviewer Guidelines
E. Site meets CDPH Radiological inspection and safety regulations.	• **CDPH Radiologic Health Branch (RHB) Inspection Report**: If site has ***current*** documentation of one of the following, give the full 9 points and survey items 2-9 will not need to be surveyed. 1) Inspection Report, ***or*** 2) Inspection Report *and* Short Form Sign-off sheet, ***or*** 3) Inspection Report *and* Notice of Violation form *and* approval letter for corrective action plan from the CA RHB. The Radiologic Inspection Report, issued by the RHB, must be present if there is radiology equipment on site. If any violations are found, one of two documents is issued to the site. The "Short Form Sign-off sheet" is issued for minimal problems that are easily corrected. The "Notice of Violation" form, requiring a site corrective action plan, is issued if there are more serious violations. All "Notice of Violation" corrective action plans must be accompanied by an approval letter from the CA RHB. **If documents are not available on site, or if reviewer is uncertain about the "current" status of documents on site, proceed to score all items 1-9.** • **Radiological equipment**: Equipment inspection, based on a "priority" rating system, is established by legislation (CA H&S Code, Section 115115). 1) Mammography equipment is inspected annually (Mammography Quality Standards Act, 21 CFR, Section 900), and must have federal FDA Certification on site ***and*** CA Mammography X-ray Equipment and Facility Accreditation Certification posted on the machine. 2) High Priority equipment (e.g. fluoroscopy, portable X-ray) is inspected every three years. 3) Medium Priority equipment is inspected every 4-5 years depending on the volume of patients, frequency of x-ray equipment use, and likelihood of radiation exposure. If reviewer is uncertain about the "current" status of equipment inspection, call the Radiological Health Branch. • **Radiology Personnel**: All certificates/licenses are posted and show expiration dates. If there are a large number of technicians, a list of names, license numbers, and expiration dates may be substituted. The Certified Radiological Technologist (CRT) certificate permits the technologist to perform all radiology films except mammography and fluoroscopy, which require separate certificates. The "Limited Permit" limits the technician to one of the ten (10) x-ray categories specified on the limited certificate: Chest, Dental laboratory, Dermatology, Extremities, Gastrointestinal, Genitourinary, Leg-podiatric, Skull, Torso-skeletal, and X-ray bone densitometry. Note: Per RHB, dexascanners do not require lead aprons or gonadal shields, however, criteria 1-7 are still required. RHB uses the ALARA (As Low As Reasonably Achievable) principle, which is the foundation of all radiation safety programs. The ALARA principle means to minimize exposure to radiation doses by employing all *reasonable* methods. Dexascanner manufacturer guidelines do not require gonadal shielding or lead aprons because the amount of radiation is very low, and there is potential for the shield to obscure the area being scanned, which could render the scan non-diagnostic. Operators do not need aprons because the beam is extremely focused, so that the amount of exposure of even "scattered" beams to an operator sitting at a seat near the scanner is about the same level as that found in the natural environment. (A traditional x-ray machine used for bone density testing, that is not a dexascanner, *may* require shielding/apron.) **Note:** The Radiologic Health Branch of the Food, Drug, and Radiation Safety Division of the CA Department of Public Health enforces the Radiation Control Laws and Regulations designed to protect both the public and employees against radiation hazards. Enforcement is carried out through licensing, registration and periodic inspection of sources of radiation, such as radiation machines. For questions regarding radiologic safety (e.g. expired or no inspection letters on site), call CDPH Radiologic Health Branch at (916) 327-5106, or for general information at (916) 440-7888. For Radiation Emergency Assistance, call 1-800-*852*-7550. Ref: CCR, Title 17, Chapter 5, Subchapter 4 regulations at www.cdph.ca.gov/programs/Pages/RadiologicHealthBranch.aspx

Criteria	V. Preventive Services Reviewer Guidelines
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	• **Examination table**: A protective barrier that is changed between patient contact is used to cover exam table surface. "Good repair" means clean and well maintained in proper working order. • **Scales**: Infant scales are marked and accurate to increments of one (1) ounce or less, and have a capacity of at least 35 pounds. Standing floor scales are marked and accurate to increments of one-fourth (1/4) pound or less, and have a capacity of at least 300 pounds. Balance beam or electronic scales are appropriate for clinic use. Balance scales have an adjustment mechanism and zeroing weight to enable routine balancing at zero. Electronic or digital scales have automatic zeroing and lock-in weight features. Spring balance scales (e.g. bathroom scales) are unsatisfactory for clinical use because, over time, the spring counter balance mechanism loses its accuracy. • **Measuring devices**: Equipment on site for measuring stature (length/height) and head circumference includes: 1) rigid 90º right angle headboard block that is perpendicular to the recumbent measurement surface, or vertical to the wall-mounted standing measurement surface. 2) flat, paper or plastic non-stretchable tape or yardstick, marked to one-eighth (1/8 in. or 1 mm) or less, attached to a firm, flat surface. The "0" of the tape is exactly at the base of the headboard for recumbent measurement, or exactly at foot level for standing measurement. 3) moveable, non-flexible foot board at 90º right angle perpendicular to the recumbent measurement surface, or a flat floor surface for standing. 4) A non-stretchable tape measuring devise marked to one-eighth (1/8 in. or 1 mm) or less for measuring head circumference. • **Basic equipment**: Exam gown sizes are appropriate to population served on site. • **Vision testing**: Site has both a literate (e.g., Snellen) and an illiterate eye chart (e.g., "E" Chart, "Kindergarten" chart, Allen Picture Card Test). "Heel" lines are aligned with center of eye chart at a distance of 10 or 20-feet depending on whether the chart is for the 10-foot or 20-foot distance. Eye charts are located in an area with adequate lighting and at height(s) appropriate to use. Disposable eye "occluders" (e.g., Dixie cups or tongue blades with back-to-back- stickers) are acceptable. Non-disposable occluders are cleaned between patients. • **Hearing testing:** Offices that provide pediatric preventive services should have an audiometer available since audiometric testing is required at preventive health visits starting at 3 years of age. PCP offices (such as Family Practitioners or General Practitioners) with less than 15% of their patients that are pediatric, and that refer all members to another provider for audiometric testing, must have a system in place that clearly demonstrates that the PCP office verifies that audiometric testing has been completed and that those results are returned to the PCP for review. **Note:** Although patient population varies from site-to-site, screening equipment listed in this section is the standard equipment most often used in performing a physical health screening examination for children and adults.

RN/MD Review only

Criteria	V. Preventive Services Reviewer Guidelines
B. Health education services are available to Plan members.	• **Health Education services:** Services may include individual instruction, group classes, family counseling and/or other health educational programs and materials provided to members by the provider, health plan, or community sponsored programs. • **Health Education materials:** Materials must be available in the appropriate threshold languages, and may be located in an accessible area on site (e.g., exam room, waiting room, health education room or area), or provided to members by clinic staff and/or by Plan upon request. Materials may include written information, audio and/or videotapes, computerized programs, and visual presentation aids. General topics for health educational materials may include Immunizations, Pregnancy, Injury Prevention, Smoking Cessation, Dental Health, Nutrition, Physical Activity, STD/HIV Prevention, Family Planning, Asthma, Hypertension, and Diabetes. • **Plan-specific Referral information:** Plan-specific informing materials and/or resources are available on site in languages that are applicable to member population(s) primarily seen on site. For example, if primarily English and Spanish-speaking members are seen on site, then Plan-specific informing materials are available on site in those languages. Although a site may not stock informing materials in ***each*** threshold language identified for the county, site personnel has access to contact resource information for locating Plan-specific informing materials in threshold languages not typically seen on site. Interpreter services are provided in all identified threshold and concentration standard languages. **Note:** Threshold languages are the primary languages spoken by Limited English Proficient (LEP) population groups residing in a county. A numeric threshold of 3,000 eligible LEP Medi-Cal beneficiaries, or a concentration standard of 1,000 residing in a single ZIP code or 1,500 in two contiguous ZIP codes establishes the threshold languages identified by DHCS for each county.

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
A. Infection control procedures for Standard/Universal precautions are followed.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Hand washing facilities**: Hand washing facilities are available in the exam room and/or utility room, and include an adequate supply of running potable water, soap and single use towels or hot air drying machines. Sinks with a standard faucet, foot-operated pedals, 4-6-inch wing-type handle, automatic shut-off systems or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelettes is acceptable until running water is available (29 CFR 1919.1030). • **Antiseptic hand cleaner**: Hand washing prevents infection transmission by removing dirt, organic material and transient microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care (Association for Professionals in Infection Control and Epidemiology, Inc., 1995). Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination. • **Waste disposal container**: Contaminated wastes (e.g. dental drapes, band aids, sanitary napkins, soiled disposal diapers) are disposed of in regular solid waste (trash) containers, and are maintained to prevent potential contamination of patient/staff areas and/or unsafe access by infants/children. Closed containers are not required for regular, solid waste trash containers. • **Isolation procedures**: Personnel are able to demonstrate or verbally explain procedure(s) used on site to isolate patients with potentially contagious conditions from other patients. If personnel are unable to demonstrate or explain site-specific isolation procedures *and* cannot locate written isolation procedure instructions, site is considered deficient. Isolation procedures will vary from site to site. **Note:** Infection Control standards are practiced on site to minimize risk of disease transmission. Site personnel are expected to apply the principles of "Standard Precautions" (CDC, 1996), used for all patients regardless of infection status. Standard precautions apply to blood, all body fluids, non-intact skin, and mucous membranes, which are treated as potentially infectious for HIV, HBV or HCV, and other bloodborne pathogens. "Universal precautions" refer to the OSHA mandated program that requires implementation of work practice controls, engineering controls, bloodborne pathogen orientation/education, and record keeping in healthcare facilities.

RN/MD Review only **VI . Infection Control Reviewer Guidelines – B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act.**

- **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan.
- **Personal Protective Equipment (PPE):** PPE for protection against bloodborne pathogen hazards is available on site and includes: water repelling gloves; clothing barrier/gown; face/eye protection (e.g., goggles/face shield); and respiratory infection protection (e.g., mask). It does not include general work clothes (e.g., uniforms, cloth lab coats) that permit liquid to soak through. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.
- **Blood and Other Potentially Infectious Materials (OPIM):** OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV-containing blood, cells, tissue, organs, cultures, medium or solutions. Containers for blood and OPIM are closable, leak proof, and labeled and/or color-coded. Double bagging is required only if leakage is possible.
- **Labels:** A warning label is affixed to red bagged regulated wastes, sharps containers, refrigerators/freezers containing blood or OPIM, containers used to store or transport blood or OPIM, and contaminated laundry or equipment for storage or transporting. The international biohazard symbol with word "BIOHAZARD" *or* the words "Biohazardous Waste" label (fluorescent orange or red-orange with contrasting lettering/symbols) is part of, or affixed to, the container. Sharps containers are labeled with the words "Sharps Waste" or with the international biohazard symbol and the word "BIOHAZARD". Individual containers of blood or OPIM are exempted from warning labels if placed inside a labeled secondary container for storage, transport, or disposal. Alternative marking or color coding may be used to label contaminated laundry or specimen containers if the alternative marking permits employees on site to recognize that container requires compliance with Universal Precautions.
- **Needlestick Safety:** Contaminated sharps are discarded immediately. Sharps containers are located close to the immediate area where sharps are used, and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped except by using a one-handed technique. Needleless systems, needles with Engineered Sharps Injury Protection (ESIP) devices, and non-needle sharps are used (incl. in emergency kits), unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant, labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g., cardboard, plastic) are acceptable. Containers are not overfilled past manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.
- **Sharps Injury documentation:** Site has a method in place to document sharps injuries. Date, time, description of exposure incident, sharp type/brand, follow-up care is documented within 14 days of injury incident.
- **Contaminated Laundry:** Contaminated laundry (soiled with blood/OPIM) is laundered by a commercial laundry service, or a washer and dryer on site. Contaminated laundry should not contain sharps, and when transported, should have the appropriate warning label (see Labels bullet above). Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable patient gowns and PPE are used on site.
- **Regulated Waste storage:** Regulated wastes include: 1) **Biohazardous wastes**, e.g., laboratory wastes, human specimens/tissue, blood/contaminated materials "known" to be infected with highly communicable diseases for humans and/or that require isolation, and 2) **Medical wastes**, e.g., liquid/semi-liquid blood or OPIM, items caked with dry blood or OPIM and capable of releasing materials during handling, and contaminated sharps. Regulated waste is contained separately from other wastes (e.g., contaminated wastes*)* and* placed in red biohazardous bags with Biohazard label, and stored in a closed container that is not accessible to unauthorized persons. If stored outside the office, a lock secures the entry door, gate or receptacle lid, and posted warning sign(s) in English *and* Spanish are visible for 25-feet: "**CAUTION-BIOHAZARDOUS WASTE STORAGE AREA- UNAUTHORIZED PERSONS KEEP OUT" or "CUIDADO-ZONA DE RESIDUOUS-BIOLOGICOS PELIGOROS-PROHIBIDA LE ENTRADA A PERSONAS NO AUTHORIZADAS."** Signs prior to the passage of the Medical Waste Act are permitted for the "life" of the sign.
- **Medical Waste disposal:** Medical wastes are hauled to a permitted offsite medical waste treatment facility, transfer station, or other registered generator by a registered hazardous waste transporter *OR* person with an approved limited-quantity hauling exemption granted by the CDPH Division of Drinking Water and Environmental Management Branch. Limited-quantity hauling exemptions are renewed annually. A medical waste tracking document that includes the name of the person transporting, number of waste containers, types of medical wastes, and date of transportation, is kept a minimum of 3 years for large waste generators and 2 years for small generators. Medical Waste (including sharps) transported by mail are only acceptable through vendors on the approved CDPH Mail Back Service List at: www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/SharpsMailBackList.pdf .

Ref: CDPH Medical Waste Management Program: www.cdph.ca.gov/certlic/medicalwaste/Pages/Contact.aspx or www.cdph.ca.gov/certlic/medicalwaste/Pages/default.aspx.
The full CA Medical Waste Management Act (H&SC 117600-11836) is at www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/MedicalWasteManagementAct.pdf

***Note:** Contaminated wastes include materials soiled with blood during the course of their use but are not within the scope of regulated wastes. Contaminated waste items need not be disposed as regulated waste in labeled red bags, but can be discarded as solid waste in regular trash receptacle.

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
C. Contaminated surfaces are decontaminated according to Cal-OSHA standards.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Routine Decontamination**: Contaminated work surfaces are decontaminated with an appropriate disinfectant (29 CFR 1910.1030). Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used and responsible personnel. • **Spill Procedure**: Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible person(s). • **Disinfectant Products**: Products used for decontamination have a current EPA-approved status. Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label. Decontamination products are reconstituted and applied according to manufacturer's guidelines for "decontamination." • **10% Bleach Solution**: 10% bleach solution that is EPA registered, effective against TB, is changed/reconstituted ***every*** 24 hours (due to instability of bleach once mixed with water). Surface is cleaned prior to disinfecting (due to presence of organic matter (e.g., dirt, blood, excrement) inactivates active ingredient, sodium hypochlorite). Surface is air dried or allowed appropriate time (stated on label) before drying. Manufacturer's directions, *specific* to every bleach product, are followed carefully. **Note:** "Contamination" means the presence or reasonably anticipated presence of blood or OPIM on any item or surface. "Decontamination" is the use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal. Current EPA product lists and information is available from the EPA, Antimicrobial Division at (703) 305-1284, or at www.epa.gov/oppad001/chemregindex.htm.

RN/MD Review only

Criteria	VI. Infection Control Reviewer Guidelines
D. Reusable medical instruments are properly sterilized after each use.	• **Deficiencies:** All deficiencies related to Infection Control must be addressed in a corrective action plan. • **Cleaning prior to sterilization**: Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization, and to locate written directions on site. • **Cold/chemical sterilization**: Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g., room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff. • **Autoclave/steam sterilization**: Autoclave manufacturer's directions are strictly followed for instrument pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. Documentation of sterilization loads includes: date, time and duration of run cycle, temperature, steam pressure, and operator of each run. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff. • **Autoclave maintenance**: Autoclave is maintained and serviced according to manufacturer's guidelines. Documentation of maintenance should include: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc. Note: If the manufacturer's guidelines are not present on site, then the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. • **Spore testing**: Autoclave spore testing is performed *at least monthly*, unless otherwise stated in manufacturer's guidelines. Documentation of biological spore testing includes: date, results, types of spore test used, person performing/documenting test results. Written procedures for performing routine spore testing and for handling positive spore test results are available on site to staff. For positive spore tests, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include: ***report*** problem, ***repair*** autoclave, ***retrieve*** all instruments sterilized since last negative spore test, ***re-test*** autoclave and ***re-sterilize*** retrieved instruments (**R**eport/**R**epair/**R**etrieve/**R**etest/**R**e-sterilize). **Note:** Sterilization methods include autoclaves (steam under pressure), Ethylene Oxide (EO) gas sterilizer, dry-heat sterilizer, and liquid chemical sterilants. Biologic spore test products vary, and are designed for use based on specific autoclave type. Biologic control testing challenges the autoclave sterilization cycle with live, highly resistant, nonpathogenic spores. If spores are killed during processing, it is assumed that all other microorganisms are also killed and that the autoclave load is sterile. • **Sterile Packages**: Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, and drawer). Sterilized package labels include date of sterilization, load run identification information, and general contents (e.g. suture set). Each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until use, unless an event causes contamination. Sterilized items are not considered sterile if package is opened, wet/moist, discolored or damaged, and should be kept removed from sterile package storage area. Site has a process for routine evaluation of sterilized packages.

Facility Site Review Survey

Attachment A

California Department of Health Care Services
Medi-Cal Managed Care Division

Health Plan_____ **IPA** _____**Site ID No.**_____ **Review Date:** _____ **Last review:** _____

Provider/Address _____ **Phone** _____ **Fax** _____ **Fire Clearance**_____
Current Yes/No

_____ **Contact person/title**_____

No. of staff on site _____ **Physician** _____ **NP** _____**CNM** _____ **PA** **Reviewer/title**

_____

_____ **RN** _____ **LVN** _____ **MA** _____ **Clerical** _____ **other** **Reviewer/title**_____

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic Type
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____ (type)	_____ AAAHC _____ JCAHO _____ CHDP _____ NCQA _____ CPSP _____ None _____ Other _____	_____ Family Practice _____ Internal Medicine _____ Pediatrics _____ OB/GYN _____ General Practice _____ Specialist _____ Mid level (type) _____	_____ Primary Care _____ Community _____ Hospital _____ FQHC _____ Rural Health _____ Other _____ (type) _____ Solo _____ Group _____ Staff/Teaching

Site Scores

	Points Poss.	Yes Pts. Given	No's	N/A's	CE's
I. Access/Safety	**(29)**				
II. Personnel	**(22)**				
III. Office Management	**(25)**				
IV. Clinical Services	**(34)**				
V. Preventive Services	**(13)**				
VI. Infection Control	**(27)**				
	(150)				
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**	**CE's**

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 150 total points poss.
4) Divide total points given by 150 or by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%
Points Given / **Total / Adjusted Points** / **Decimal Score** / **Compliance Rate**

Note: CE's column may be used for easy reference to see if there are Critical Elements that trigger a CAP.

Compliance Rate

_____ **Exempted Pass: 90% or above** (*without* deficiencies in Critical Elements, Pharmaceutical Services or Infection Control)

_____ **Conditional Pass: 80-89%, or 90% and above** *with* deficiencies in Critical Elements, Pharmaceutical Services or Infection Control

_____ **Not Pass: Below 80%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

BLANK PAGE

I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Site is accessible and useable by individuals with physical disabilities. 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III) Sites must have the following safety accommodations for physically disabled persons:					
1) Clearly marked (blue) curb or sign designating disabled-parking space near accessible primary entrance.	**1)** ____	**1)**_____	**1)**_____	**1**	
2) Pedestrian ramps have a level landing at the top and bottom of the ramp.	**2)**_____	**2)**_____	**2)**_____	**1**	
3) Exit doorway openings allow for clear passage of a person in a wheelchair.	**3)**_____	**3)**_____	**3)**_____	**1**	
4) Accessible passenger elevator or reasonable alternative for multi-level floor accommodation.	**4)**_____	**4)**_____	**4)**_____	**1**	
5) Clear floor space for wheelchair in waiting area and exam room.	**5)**_____	**5)**_____	**5)**_____	**1**	
6) Wheelchair accessible restroom facilities or reasonable alternative.	**6)**_____	**6)**_____	**6)**_____	**1**	
7) Wheelchair accessible hand washing facilities or reasonable alternative.	**7)**_____	**7)**_____	**7)**_____	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

I. Access/Safety (continued on next page)

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Site environment is maintained in a clean and sanitary condition. 8 CCR §5193; 28 CCR §1300.80					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean and well maintained.	**1)**_____	**1)**_____	**1)**_____	**1**	
2) Restrooms are clean and contain appropriate sanitary supplies.	**2)**_____	**2)**_____	**2)**_____	**1**	
C. Site environment is safe for all patients, visitors and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34					
There is evidence that staff has received safety training and/or has safety information available in the following: 1) Fire safety and prevention	**1)**_____	**1)**_____	**1)**_____	**1**	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	**2)**_____	**2)**_____	**2)**_____	**1**	
The following fire and safety precautions are evidenced on site: 3) Lighting is adequate in all areas to ensure safety.	**3)**_____	**3)**_____	**3)**_____	**1**	
4) **Exit doors and aisles are unobstructed and egress (escape) accessible**.	**4)**_____	**4)**_____	**4)**_____	**2**	
5) Exit doors are clearly marked with "Exit" signs.	**5)**_____	**5)**_____	**5)**_____	**1**	
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	**6)**_____	**6)**_____	**6)**_____	**1**	
7) Electrical cords and outlets are in good working condition.	**7)**_____	**7)**_____	**7)**_____	**1**	
8) At least one type of fire fighting/protection equipment is accessible at all times.	**8)**_____	**8)**_____	**8)**_____	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

I. Access/Safety (continued on next page)

RN/MD Review only

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week. 22 CCR §51056, §53216; 28 CCR §1300.67					
1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.	1)_____	1)_____	1)_____	1	
2) Emergency equipment is stored together in easily accessible location.	2)_____	2)_____	2)_____	1	
3) Emergency phone number contacts are posted.	3)_____	3)_____	3)_____	1	
Emergency medical equipment appropriate to practice/patient population is available on site: 4) **Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.**	4)_____	4)_____	4)_____	2	
5) Anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), appropriate sizes of ESIP needles/syringes and alcohol wipes.	5)_____	5)_____	5)_____	1	
6) Medication dosage chart (or other method for determining dosage) is kept with emergency medications.	6)_____	6)_____	6)_____	1	
There is a process in place on site to: 7) Document checking of emergency equipment/supplies for expiration and operating status at least monthly.	7)_____	7)_____	7)_____	1	
8) Replace/re-stock emergency equipment immediately after use.	8)_____	8)_____	8)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

I. Access/Safety (continued from previous page)

RN/MD Review only

Site Access/Safety Survey Criteria	Yes	No	N/A	Wt.	Site Score
E Medical and lab equipment used for patient care is properly maintained. CA Health & Safety Code §111255; 28 CCR §1300.80; 21 CFR §800-1299					
1) Medical equipment is clean.	**1)_____**	**1)_____**	**1)_____**	**1**	
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.	**2)_____**	**2)_____**	**2)_____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **TOTALS**					

II. Personnel (continued on next page)

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Professional health care personnel have current California licenses and certifications. CA Business & Professional (B&P) Code §2050, §2085**,** §2725, §2746, §2834, §3500, §4110; CCR, Title 16, §1355.4, §1399.547 1) All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current. Notification is provided to each member that the MD(s) is licensed and regulated by the Medical Board, and that the Physician Assistant(s) is licensed and regulated by the Physician Assistant Committee.	**1)_____**	**1)_____**	**1)_____**	**1**	
B. Health care personnel are properly identified. CA B&P Code §680, AB 1439 1) Health care personnel wear identification badges/tags printed with name and title.	**1)_____**	**1)_____**	**1)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Site personnel are qualified and trained for assigned responsibilities. CA B&P Code §2069; 16 CCR §1366; 22 CCR §75034, §75035					
1) **Only qualified/trained personnel retrieve, prepare or administer medications.**	**1)_____**	**1)_____**	**1)_____**	**2**	
2) Only qualified/trained personnel operate medical equipment.	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Documentation of education/training for non-licensed medical personnel is maintained on site.	**3)_____**	**3)_____**	**3)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined. 16 CCR §1379, §1399.540, §1399.545, §1474, CA B&P Code §2725.1					
1) Standardized Procedures provided for Nurse Practitioners (NP) and/or Certified Nurse Midwives (CNM).	1)_____	1)_____	1)_____	1	
2) A Delegation of Services Agreement defines the scope of services provided by Physician Assistants (PA) and Supervisory Guidelines define the method of supervision by the Supervising Physician.	2)_____	2)_____	2)_____	1	
3) Standardized Procedures, Delegation of Services Agreements and Supervisory Guidelines are revised, updated and signed by the supervising physician and NPMP when changes in scope of services occur.	3)_____	3)_____	3)_____	1	
4) Each NPMP that prescribes controlled substances has a valid DEA Registration Number.	4)_____	4)_____	4)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Non-physician medical practitioners (NPMP) are supervised according to established standards. B&P Code 3516(b); W&I Code 14132.966					
The designated supervising physician(s) on site: 1) ratio to number of NPMPs does not exceed established ratios in any combination. a) 1:4 Nurse Practitioners b) 1:3 Certified Nurse Midwives c) 1:4 Physicians Assistants	1)_____	1)_____	1)_____	1	
2) The designated supervising or back-up physician is available in person or by electronic communication at all times when a NPMP is caring for patients.	2)_____	2)_____	2)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

II. Personnel (continued on next page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
F. Site personnel receive safety training/information. 8 CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030 There is evidence that site staff has received training and/or information on the following:					
1) Infection control/universal precautions (annually)	**1)_____**	**1)_____**	**1)_____**	**1**	
2) Blood Borne Pathogens Exposure Prevention (annually)	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Biohazardous Waste handling (annually)	**3)_____**	**3)_____**	**3)_____**	**1**	
4) Child/Elder/Domestic Violence Abuse	**4)_____**	**4)_____**	**4)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

II. Personnel (continued from previous page)

RN/MD Review only

Site Personnel Survey Criteria	Yes	No	N/A	Wt.	Site Score
G. Site personnel receive training and/or information on member rights. 22 CCR §51009, §51014.1, §51305.1, §53452, §53858; 28 CCR §1300.68 There is evidence that site staff has received training and/or information on the following:					
1) Patient Confidentiality	1)_____	1)_____	1)_____	1	
2) Informed consent, including Human Sterilization	2)_____	2)_____	2)_____	1	
3) Prior Authorization requests	3)_____	3)_____	3)_____	1	
4) Grievance/Complaint Procedure	4)_____	4)_____	4)_____	1	
5) Sensitive Services/Minors' Rights	5)_____	5)_____	5)_____	1	
6) Health Plan referral process/procedures/resources	6)_____	6)_____	6)_____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores. **Totals**					

III. Office Management (continued on next page)

RN/MD Review only (#B)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Physician coverage is available 24 hours a day, 7 days a week. 22 CCR §56500, §53855					
The following are maintained current on site:					
1) Clinic office hours are posted, or readily available upon request.	1)_____	1)_____	1)_____	1	
2) Provider office hour schedules are available to staff.	2)_____	2)_____	2)_____	1	
3) Arrangement/schedule for after-hours, on-call, supervisory back-up physician coverage is available to site staff.	3)_____	3)_____	3)_____	1	
4) Contact information for off-site physician(s) is available at all times during office hours.	4)_____	4)_____	4)_____	1	
5) After-hours emergency care instructions/telephone information is made available to patients.	5)_____	5)_____	5)_____	1	
B. There is sufficient health care personnel to provide timely, appropriate health care services. 22 CCR §53855; 28 CCR §1300.67.1, §1300.80					
1) Appropriate personnel handle emergent, urgent, and medical advice telephone calls.	1)_____	1)_____	1)_____	1	
2) Telephone answering machine, voice mail system or answering service is used whenever office staff does not directly answer phone calls.	2)_____	2)_____	2)_____	1	
3) Telephone system, answering service, recorded telephone information, and recording device are periodically checked and updated.	3)_____	3)_____	3)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

III. Office Management (continued on next page)

RN/MD Review only (#C)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Health care services are readily available. 22 CCR §56000(2)					
1) Appointments are scheduled according to patients' stated clinical needs within the timeliness standards established for Plan members.	1)_____	1)_____	1)_____	1	
2) Patients are notified of scheduled routine and/or preventive screening appointments.	2)_____	2)_____	2)_____	1	
3) There is a process in place verifying follow-up on missed and canceled appointments.	3)_____	3)_____	3)_____	1	
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members. 22 CCR §53851; 28 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1)_____	1)_____	1)_____	1	
2) Persons providing language interpreter services on site are trained in medical interpretation.	2)_____	2)_____	2)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

III. Office Management (continued on next page)

RN/MD Review only (#E)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Procedures for timely referral/consultative services are established on site. 22 CCR §53851; 28 CCR §1300.67 and §1300.80 Office practice procedures allow timely provision and tracking of: 1) Processing internal and external referrals, consultant reports and diagnostic test results 2) **Physician review and follow-up of referral/consultation reports and diagnostic test results**.	1)_____ 2)_____	1)_____ 2)_____	1)_____ 2)_____	1 2	
F. Member Grievance/Complaint processes are established on site. 22 CCR §53858, §56260 1) Phone number(s) for filing grievances/complaints are located on site. 2) Complaint forms and a copy of the grievance procedure(s) are available on site.	1)_____ 2)_____	1)_____ 2)_____	1)_____ 2)_____	1 1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

III. Office Management (continued from previous page)

RN/MD Review only (#H)

Office Management Survey Criteria	Yes	No	N/A	Wt.	Site Score
G. Medical records are available for the practitioner at each scheduled patient encounter. 22 CCR §75055; 28 CCR §1300.80					
1) Medical records are readily retrievable for scheduled patient encounters.	1)_____	1)_____	1)_____	1	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	2)_____	2)_____	2)_____	1	
H. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53861, §75055; §28 CCR §1300.80; CA Civil Code §56.10 (Confidentiality of Medical Information Act)					
1) Exam rooms and dressing areas safeguard patients' right to privacy.	1)_____	1)_____	1)_____	1	
2) Procedures are followed to maintain the confidentiality of personal patient information.	2)_____	2)_____	2)_____	1	
3) Medical record release procedures are compliant with State and federal guidelines.	3)_____	3)_____	3)_____	1	
4) Storage and transmittal of medical records preserves confidentiality and security.	4)_____	4)_____	4)_____	1	
5) Medical records are retained for a minimum of 7 years according to 22 CCR Section 75055.	5)_____	5)_____	5)_____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

IV. Clinical Services - Pharmaceutical (continued on next page)

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Drugs and medication supplies are maintained secure to prevent unauthorized access. CA B&P Code §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22; 16 CCR §1356.3					
1) Drugs are stored in specifically designated cupboards, cabinets, closets or drawers.	1)_____	1)_____	1)_____	1	
2) Prescription, sample and over-the counter drugs, hypodermic needles/syringes, prescription pads are securely stored in a lockable space (cabinet or room) within the office/clinic.	2)_____	2)_____	2)_____	1	
3) Controlled drugs are stored in a locked space accessible only to authorized personnel.	3)_____	3)_____	3)_____	1	
4) A dose-by-dose controlled substance distribution log is maintained.	4)_____	4)_____	4)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

IV. Clinical Services - Pharmaceutical (continued on next page)

RN/MD Review only

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Drugs are handled safely and stored appropriately. 22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351					
1) Drugs are prepared in a clean area, or "designated clean" area if prepared in a multipurpose room.	1)_____	1)_____	1)_____	1	
2) Drugs for external use are stored separately from drugs for internal use.	2)_____	2)_____	2)_____	1	
3) Items other than medications in refrigerator/freezer are kept in a secured, separate compartment from drugs.	3)_____	3)_____	3)_____	1	
4) Refrigerator thermometer temperature is 35°-46° Fahrenheit or 2°-8° Centigrade (at time of site visit).	4)_____	4)_____	4)_____	1	
5) Freezer thermometer temperature is 5° Fahrenheit or –15° Centigrade, or lower (at time of site visit).	5)_____	5)_____	5)_____	1	
6) Daily temperature readings of medication refrigerator and freezer are documented.	6)_____	6)_____	6)_____	1	
7) Drugs are stored separately from test reagents, germicides, disinfectants and other household substances.	7)_____	7)_____	7)_____	1	
8) Hazardous substances are appropriately labeled.	8)_____	8)_____	8)_____	1	
9) Site has method(s) in place for drug and hazardous substance disposal.	9)_____	9)_____	9)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

IV. Clinical Services - Pharmaceutical (continued from previous page)

Pharmaceutical Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Drugs are dispensed according to State and federal drug distribution laws and regulations. CA B&P Code §4024, §4076, §4170, §4171, §4173, §4174; 22 CCR §75032, §75033, §75036, §75037(a-g), §75038, §75039; 16 CCR §1718.1; 21 CFR §211.137; 42 USC 6A §300AA-26					
1) There are no expired drugs on site.	1)_____	1)_____	1)_____	1	
2) Site has a procedure to check expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas.	2)_____	2)_____	2)_____	1	
3) All stored and dispensed prescription drugs are appropriately labeled.	3)_____	3)_____	3)_____	1	
4) **Only lawfully authorized persons dispense drugs to patients.**	4)_____	4)_____	4)_____	2	
5) Current Vaccine Information Sheets (VIS) for distribution to patients are present on site.	5)_____	5)_____	5)_____	1	
6) If there is a pharmacy on site, it is licensed by the CA State Board of Pharmacy.	6)_____	6)_____	6)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

IV. Clinical Services - Laboratory

Laboratory Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations. 17 CCR §1050; 22 CCR §51211.2, §51137.2; B&P Code §1220; 42 USC 263a; Public Law 100-578					
1) Laboratory test procedures are performed according to current site-specific CLIA certificate.	**1)_____**	**1)_____**	**1)_____**	**1**	
2) Testing personnel performing clinical lab procedures have been trained.	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Lab supplies (e.g. vacutainers, vacutainer tubes, culture swabs, test solutions) are inaccessible to unauthorized persons.	**3)_____**	**3)_____**	**3)_____**	**1**	
4) Lab test supplies are not expired.	**4)_____**	**4)_____**	**4)_____**	**1**	
5) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	**5)_____**	**5)_____**	**5)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

IV. Clinical Services - Radiology

Radiology Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
E. Site meets CDPH Radiological inspection and safety regulations. 17 CCR §30255, §30305, §30404, §30405					
1) Site has current CA Radiologic Health Branch Inspection Report, if there is radiological equipment on site.	**1)_____**	**1)_____**	**1)_____**	**1**	
The following documents are <u>posted</u> on site: 2) Current copy of Title 17 with a posted notice about availability of Title 17 and its location	**2)_____**	**2)_____**	**2)_____**	**1**	
3) "Radiation Safety Operating Procedures" posted in highly visible location.	**3)_____**	**3)_____**	**3)_____**	**1**	
4) "Notice to Employees Poster" posted in highly visible location.	**4)_____**	**4)_____**	**4)_____**	**1**	
5) "Caution, X-ray" sign posted on or next to door of each room that has X-ray equipment	**5)_____**	**5)_____**	**5)_____**	**1**	
6) Physician Supervisor/Operator certificate posted *and* within current expiration date	**6)_____**	**6)_____**	**6)_____**	**1**	
7) Technologist certificate posted *and* within current expiration date	**7)_____**	**7)_____**	**7)_____**	**1**	
The following radiological protective equipment is present on site: 8) Operator protection devices: radiological equipment operator must use lead apron or lead shield.	**8)_____**	**8)_____**	**8)_____**	**1**	
9) Gonadal shield (0.5 mm or greater lead equivalent): for patient procedures in which gonads are in direct beam.	**9)_____**	**9)_____**	**9)_____**	**1**	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					

V. Preventive Services (continued on next page)

Preventive Services Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases. 22 CCR §53851, §56210; 28 CCR §1300.67					
Examination equipment, appropriate for primary care services, is available on site:					
1) Exam tables and lights are in good repair.	**1)_____**	**1)_____**	**1)_____**	**1**	
2) Stethoscope and sphygmomanometer with various size cuffs (e.g. child, adult, obese/thigh).	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Thermometer with a numeric reading**.**	**3)_____**	**3)_____**	**3)_____**	**1**	
4) Scales: standing balance beam and infant scales.	**4)_____**	**4)_____**	**4)_____**	**1**	
5) Measuring devices for stature (height/length) measurement *and* head circumference measurement.	**5)_____**	**5)_____**	**5)_____**	**1**	
6) Basic exam equipment: percussion hammer, tongue blades, patient gowns.	**6)_____**	**6)_____**	**6)_____**	**1**	
7) Eye charts (literate and illiterate) and occluder for vision testing.	**7)_____**	**7)_____**	**7)_____**	**1**	
8) Ophthalmoscope.	**8)_____**	**8)_____**	**8)_____**	**1**	
9) Otoscope with adult and pediatric ear speculums.	**9)_____**	**9)_____**	**9)_____**	**1**	
10) Audiometer in quiet location for testing.	**10)____**	**10)____**	**10)____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

V. Preventive Services (continued from previous page)

RN/MD Review only

Health Education Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Health education services are available to Plan members. 22 CCR §53851; 28 CCR 1300.67					
Health education materials and Plan-specific resource information are: 1) readily accessible on site, or are made available upon request,	1)_____	1)_____	1)_____	1	
2) applicable to the practice and population served on site,	2)_____	2)_____	2)_____	1	
3) available in threshold languages identified for county and/or area of site location.	3)_____	3)_____	3)_____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
A. Infection control procedures for Standard/Universal precautions are followed. 8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042					
1) Antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.	**1)_____**	**1)_____**	**1)_____**	**1**	
2) A waste disposal container is available in exam rooms, procedure/treatment rooms and restrooms.	**2)_____**	**2)_____**	**2)_____**	**1**	
3) Site has procedure for effectively isolating infectious patients with potential communicable conditions.	**3)_____**	**3)_____**	**3)_____**	**1**	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. 8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H& S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.					
1) **Personal Protective Equipment is readily available for staff use.**	1)_____	1)_____	1)_____	2	
2) **Needlestick safety precautions are practiced on site.**	2)_____	2)_____	2)_____	2	
3) All sharp injury incidents are documented.	3)_____	3)_____	3)_____	1	
4) **Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.**	4)_____	4)_____	4)_____	2	
5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.	5)_____	5)_____	5)_____	1	
6) Contaminated laundry is laundered at the workplace or by a commercial laundry service.	6)_____	6)_____	6)_____	1	
7) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.	7)_____	7)_____	7)_____	1	
8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.	8)_____	8)_____	8)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

VI. Infection Control (continued on next page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. 8 CCR §5193; CA H&S Code §118275					
1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.	1)_____	1)_____	1)_____	1	
2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.	2)_____	2)_____	2)_____	1	
Disinfectant solutions used on site are: 3) approved by the Environmental Protection Agency (EPA).	3)_____	3)_____	3)_____	1	
4) effective in killing HIV/HBV/TB.	4)_____	4)_____	4)_____	1	
5) used according to product label for desired effect.	5)_____	5)_____	5)_____	1	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

VI. Infection Control (continued from previous page)

RN/MD Review only

Infection Control Survey Criteria	Yes	No	N/A	Wt.	Site Score
D. Reusable medical instruments are properly sterilized after each use. 22 CCR §53230, §53856					
1) Written site-specific policy/procedures or Manufacturer's Instructions for instrument/equipment sterilization are available to staff.	1)_____	1)_____	1)_____	1	
Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures: 2) Cleaning reusable instruments/equipment prior to sterilization	2)_____	2)_____	2)_____	1	
3) Cold chemical sterilization	3)_____	3)_____	3)_____	1	
4) Autoclave/steam sterilization	4)_____	4)_____	4)_____	1	
5) Autoclave maintenance	5)_____	5)_____	5)_____	1	
6) **Spore testing of autoclave/steam sterilizer with documented results (at least monthly)**	6)_____	6)_____	6)_____	2	
7) Sterilized packages are labeled with sterilization date and load identification information.	7)_____	7)_____	7)_____	1	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
Totals					

Medical Record Review Guidelines

California Department of Health Care Services
Medi-Cal Managed Care Division

Purpose: Medical Record Survey Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey, and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Survey score is based on a review standard of 10 records per individual primary care physician (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each PCP, five (5) adult and/or obstetric records and five (5) pediatric records. For sites with *only* adult, *only* obstetric, or *only* pediatric patient populations, all ten records surveyed will be in *only* one preventive care service area. Sites where documentation of patient care by all PCPs on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each PCP sharing the records. A minimum of ten shared records shall be reviewed for 2-3 PCPs, twenty records for 4-6 PCPs, and thirty records for 7 or more PCPs. Survey criteria to be reviewed *only* by a R.N. or physician are labeled "**RN/MD Review only".**

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single PCP. If 20 records are reviewed, divide total points given by the "adjusted" total points possible. If 30 records are reviewed, divide total points given by the "adjusted" total points possible. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.

Step 2: Add points given for all six (6) sections.

(Format points given)
(Documentation points given)
(Coordination/Continuity-of-care points given)
(Pediatric Preventive points given)
(Adult Preventive points given)
+ (OB/CPSP Preventive points given)
= **(Total points given)**

Step 3: Subtract the "N/A" points from total points possible.

(Total points possible)
– (N/A points)
= ("Adjusted" total points possible)

Step 4: Divide total points given by the "adjusted" points possible, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Total points given}}{\text{"Adjusted" total points possible}}$$

Example: $\frac{267}{305} = 0.875 \times 100 =$ **88%**

Rationale: A well-organized medical record keeping system supports effective patient care, information confidentiality and quality review processes.

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	Practitioners are able to readily identify each individual treated. A medical record is started upon the initial visit. "Family charts" are not acceptable.
B. Member identification is on each page.	Member identification includes first and last name, and/or a unique identifier established for use on clinical site. Electronically maintained records and printed records from electronic systems must contain member identification.
C. Individual personal biographical information is documented.	Personal biographical information includes date of birth, current address, home/work phone numbers, and name of parent(s) /legal guardian if member is a minor. If member refused to provide information, "refused" is documented in the medical record. Do not deduct points if member has refused to provide all personal information requested by the practitioner.
D. Emergency "contact" is identified.	The name and phone number of an "emergency contact" person is identified for all members. Listed emergency contacts may include a spouse, relative or friend, and must include at least one of the following: home, work, pager, cellular or message phone number. If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts. Adults and emancipated minors may list anyone of their choosing. If a member refuses to provide an emergency contact, "refused" is noted in the record. Do not deduct points if member has refused to provide personal information requested by the practitioner.
E. Medical records are consistently organized.	Contents and format of printed and/or electronic records within the practice site are uniformly organized.
F. Chart contents are securely fastened.	Printed chart contents are securely fastened, attached or bound to prevent medical record loss. Electronic medical record information is readily available.
G. Member's assigned primary care physician (PCP) is identified.	The assigned PCP is ***always*** identified when there is more than one PCP on site and/or when the member has selected health care from a non-physician medical practitioner. Since various methods are used to identify the assigned PCP, reviewers must identify specific method(s) used at each individual site such as Health Plan ID Card, practitioner stamp, etc.
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	The primary language and *requests* for language and/or interpretation services by a non-or limited-English proficient member are documented. Member refusal of interpreter services is documented. The PCP and/or appropriate clinic staff member who speak the member's language fluently can be considered a qualified interpreter. Family or friends should not be used as interpreters, unless specifically requested by the member. Language documentation is not necessary "N/A," if English is the primary language, however, if "English" *is documented,* the point may be given. **Note:** Title VI of the Civil Rights Act of 1964 prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. Since Medi-Cal is partially funded by federal funds, ***all*** Plans with Medi-Cal LEP members must ensure that these members have equal access to all health care services (MMCD Policy Letter 99-03).

Rationale: Well-documented records facilitate communication and coordination, and promote efficiency and effectiveness of treatment. **RN/MD Review only**

Criteria	II. Documentation Reviewer Guidelines
A. Allergies are prominently noted.	Allergies and adverse reactions are listed in a prominent, easily identified and consistent location in the medical record. If member has no allergies or adverse reactions, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), or ∅ is documented.
B. Chronic problems and/or significant conditions are listed.	Documentation may be on a separate "problem list," or a clearly identifiable problem list in the progress notes. All chronic or significant problems are considered current if no "end date" is documented. **Note:** Chronic conditions are current long-term, on-going conditions with slow or little progress.
C. Current *continuous* medications are listed.	Documentation may be on a separate "medication list," or a clearly identifiable medication list in the progress notes. List of current, on-going medications identifies the medication name, strength, dosage, route (if other than oral), and frequency. Discontinued medications are noted on the medication list or in progress notes.
D. Signed Informed Consents are present when any invasive procedure is performed.	Adults, parents/legal guardians of a minor or emancipated minors may sign consent forms for operative and invasive procedures.* Persons under 18 years of age are emancipated if they have entered into a valid marriage, are on military active duty, or have received a court declaration of emancipation under the CA Family Code, Section 7122. Note: Human sterilization requires DHCS Consent Form PM 330. * An invasive procedure is a medical procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body. Very minor procedures such as drawing blood testing, umbilical cord blood donations and a few other very specific tests are not considered invasive and do not require a consent. Consent is implied by entering the provider's office or lab and allowing blood to be drawn. Ref: National Institutes of Health; American Cancer Society. Note: Written consent for HIV testing is no longer required (AB 682) 2007.
E. Advance Health Care Directive information is offered. (Adults 18 years or age or older; Emancipated minors)	Adult medical records include documentation of whether the member has been offered information or has executed an Advance Health Care Directive (California Probate Code, Sections 4701).
F. All entries are signed, dated and legible.	**Signature:** includes the first initial, last name and title of health care personnel providing care, including Medical Assistants. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Note: In electronic records (EMR), methods to document signatures (and/or authenticate initials) will vary, and must be individually evaluated. Reviewers should assess the log-in process and may need to request print-outs of entries. **Date:** includes the month/day/year. Only standard abbreviations are used. Entries are in reasonably consecutive order by date. Handwritten documentation does not contain skipped lines or empty spaces where information can be added. Entries are not backdated or inserted into spaces above previous entries. Omissions are charted as a new entry. Late entries are explained in the medical record, signed and dated. **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
G. Errors are corrected according to legal medical documentation standards.	The person that makes the documentation error corrects the error. One correction method is (single line drawn through the error, with the writer's initial and date written above or near the lined-through entry). Similar variations such as (single line and initial) are also used. The corrected information is written as a separate entry and includes date of the entry, signature (or initials), and title. There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. Note: Reviewers must determine the method used for error corrections for EMR on a case by case basis. This should include the log-in process and whether the EMR allows for corrections to be made after entries are made.

Rationale: Medical records support coordination and continuity-of-care with documentation of past and present health status, medical treatment and future plans of care.
RN/MD Review only

Criteria	III. Coordination/Continuity of Care Reviewer Guidelines
A. History of present illness is documented.	Each focused visit (e.g., primary care, urgent care, acute care, etc.) includes a documented history of present illness.
B. Working diagnoses are consistent with findings.	Each visit has a documented "working" diagnosis/impression derived from a physical exam, and/or "Subjective" information such as chief complaint or reason for the visit as stated by member/parent. The documented "Objective" information (such as assessment, findings and conclusion) relate to the working diagnoses. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of documented information, but shall initiate the peer review process as appropriate.
C. Treatment plans are consistent with diagnoses.	A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis. **Note:** For scoring purposes, reviewers shall ***not make determinations*** about the "*rightfulness or wrongfulness"* of treatment rendered or care plan, but shall initiate the peer review process as appropriate.
D. Instruction for follow-up care is documented.	Specific follow-up instructions and a definite time for return visit or other follow-up care is documented. Time period for return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed).
E. Unresolved and/or continuing problems are addressed in subsequent visit(s).	Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit. Documentation demonstrates that the practitioner follows up with members about treatment regimens, recommendations, and counseling.
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	There is documented evidence of practitioner review of records such as diagnostic studies, lab tests, X-ray reports, consultation summaries, inpatient/discharge records, emergency and urgent care reports, and all abnormal and/or "STAT" reports. Evidence of review may include the practitioner's initials or signature on the report, notation in the progress notes, or other site-specific method of documenting practitioner review. Note: Electronically maintained medical reports must also show evidence of practitioner review, and may differ from site to site.
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate.	Consultation reports and diagnostic test results are documented for ordered requests. Abnormal test results/diagnostic reports have explicit notation in the medical record, including attempts to contact the member/guardian, follow-up treatment, instructions, return office visits, referrals and/or other pertinent information. Missed/broken appointments for diagnostic procedures, lab tests, specialty appointments and/or other referrals are noted, and include attempts to contact the member/parent and results of follow-up actions.
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	Documentation includes incidents of missed/broken appointments, cancellations or "No shows" with the PCP office. Attempts to contact the member or parent/guardian and the results of follow-up actions are documented.

Rationale: Pediatric preventive services are provided in accordance with current AAP periodicity, and include CHDP assessments. **RN/MD Review only**

Criteria	IV. Pediatric Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) IHA includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* to identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member or parent/guardian within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member/parent refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Well-Child Visit	
1. Well-child exam completed at age appropriate frequency	Health assessments containing CHDP age-appropriate content requirements are provided according to the most recent AAP periodicity schedule for pediatric preventive health care. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. Follow-up care or referral is provided for identified physical health problems as appropriate. **Note**: Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, the AAP scheduled visit must include all assessment components required by the CHDP program for the lower age nearest to the current age of the child.
2. Anthropometric measurements	Height and weight are documented at each well-child exam. Include head circumference for infants up to 24 months.
3. BMI Percentile	BMI percentile is plotted on an appropriate CDC growth chart for each well-child exam ages 2-20 years. Note: The BMI percentile calculation is based on the CDC's BMI-for-age- growth charts, which indicates the relative position of the patient's BMI number among others of the same sex and age. Ref: www.cdc.gov/nccdphp/dnpa/bmi/index.htm
4. Developmental screening	Developmental surveillance at each visit and screening for developmental disorders at the 9th, 18th and 30th month visits. Children identified with potential delays require further assessment and/or referral. (Ref: AAP and CHDP periodicity schedules)
5. Anticipatory guidance	Includes age appropriate counseling/health education provided to parent or pediatric member.
6. STI screening on all sexually active adolescents, incl. chlamydia for females	All sexually active adolescents should be screened for sexually transmitted infections (STIs), including chlamydia for females.
7. Pap smear on sexually active females	Pap smear within 3 years of onset of sexual intercourse.
D. Vision Screening	Age-appropriate visual screening occurs at each health assessment visit, with referral to optometrist/ophthalmologist as appropriate. **Note:** Although specific screening details are not generally documented in the medical record, screening for infants and children (birth to 3 years) may consist of evaluations such as external eye inspection, ophthalmoscopic red reflex examination, or corneal penlight evaluation. Visual acuity screening usually begins at age 3 years.

Criteria	IV. Pediatric Preventive Reviewer Guidelines RN/MD Review only (continued from previous page)
E. Hearing Screening	Non-audiometric screening for infants/children (2 months to 3 years) includes family and medical history, physical exam and age-appropriate screening. Audiometric screening for children and young adults (3 -20) is done at each health assessment visit and includes follow-up care as appropriate. A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.
F. Nutrition Assessment	Screening includes: 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother). Based on problems/conditions identified, nutritionally at-risk children under 5 years of age are referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program for medical nutrition therapy or other in-depth nutritional assessment.
G. Dental Assessment	Inspection of the mouth, teeth and gums is performed at every health assessment visit. Children are referred to a dentist ***at any age*** if a dental problem is detected or suspected. Beginning at 3 years of age, all children are referred annually to a dentist regardless of whether a dental problem is detected or suspected.
H. Blood Lead Screening Test	Children receiving health services through Medi-Cal Managed Care Plans must have blood lead level (BLL) testing as follows: 1) at 12 month *and* 24 months of age, 2) between 12 months and 24 months of age *if* there is no documented evidence of BLL testing at 12 months or thereafter, *and* 3) between 24 months and 72 months of age *if* there is no documented evidence of BLL testing at 24 months or thereafter. Elevated BLL of 10 µg/dL or greater require additional BLL and follow-up in accordance with current DHCS policy or as follows: • 10-14 µg/dL: Confirm with venous sample within 3 months of original test; • 15-19 µg/dL: Confirm with venous sample within 2 months of original test, then retest 2 months following the confirmatory testing; • 20-44 µg/dL: Confirm with venous sample in 1 week to 1 month, depending on severity of BLL; • 45-59 µg/dL: Retest with venous sample within 48 hour; • 60-69 µg/dL: Retest with venous sample within 24 hours; • ≥ 70 µg/dL: EMERGENCY. Retest immediately with venous sample. Children with elevated BLLs are referred to the local Childhood Lead Poisoning Prevention Branch or, if none, to the local health department. All children with confirmed (venous) BLLs of ≥ 20 µg/dL must be referred to CCS.
I. Tuberculosis Screening	All children are assessed for risk of exposure to tuberculosis (TB) at each health assessment. The Mantoux skin test, or other approved TB infection screening test,* is administered to children *identified at risk,* if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and treatment. *Per June 25, 2010 CDC MMWR, FDA approved IGRA serum TB tests, i.e., QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). The Mantoux is preferred over IGRA for children under 5 years of age. Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm
J. Childhood Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services. **RN/MD Review only**

Criteria	V. Adult Preventive Reviewer Guidelines (continued on next page)
A. Initial Health Assessment (IHA) Includes H&P and IHEBA	The IHA (H&P and IHEBA) enables the PCP to assess current acute, chronic and preventive needs *and* identify those Members whose health needs require coordinated services with appropriate community resources/other agencies not covered by the Plan.
1. History and physical (H&P)	**New members**: An H&P is completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems. If an H&P is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
2. Individual Health Education Behavioral Assessment (IHEBA)	**New members**: An age-appropriate IHEBA ("Staying Healthy" or other DHCS-approved tool) is completed by the member within 120 days of the effective date of enrollment into the Plan, or within the 12 months prior to Plan enrollment. Staff may assist. The IHEBA has evidence of practitioner review such as signature/initials, and dates and intervention codes, which may be documented on the IHEBA form, in progress notes, or other areas of the paper or electronic medical record system. If an initial IHEBA is not found in the medical record, the reasons (e.g., member's refusal, missed appointment) and contact attempts to reschedule are documented.
B. Subsequent Periodic IHEBA	An age-appropriate IHEBA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial IHEBA.
C. Periodic Health Evaluation according to most recent USPSTF Guidelines.	Periodic health evaluations occur in accordance with the frequency that is appropriate for individual risk factors. The type, quantity and frequency of preventive services will depend on the most recent USPSTF recommendations. In addition to USPSTF recommendations, periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner. Example: A patient with elevated cholesterol levels and other risk factors for coronary heart disease (CHD) may be evaluated more frequently than other persons of the same age without similar risk factors.
D. High Blood Pressure Screening	All adults 18 years and older including those without known hypertension are screened. A blood pressure (B/P) measurement for the normotensive adult is documented at least once every 2 years if the last systolic reading was below 120 mmHg and the diastolic reading was below 80 mmHg. B/P is measured annually if the last systolic reading was 120 to 139 mmHg and the diastolic reading was 80 to 89 mmHg. USPSTF link for high blood pressure screening: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.htm
E. Obesity Screening	Includes weight and body mass index (BMI).
F. Lipid Disorders Screening	All men (ages 35 years and older) are screened. Women (ages 45 years and older) are screened if at increased risk for coronary heart disease. Screening includes measurement of total cholesterol (TC) and high-density lipoprotein cholesterol (HDL-C). **Note:** Men under 35 years and women under 45 year may also be screened for lipid disorders if at increased risk for coronary artery disease. USPSTF link for lipid disorder screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspschol.htm

Rationale: Current Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (USPSTF) Report is the minimum standard for adult preventive health services. **RN/MD Review only**

Criteria	V. Adult Preventive Reviewer Guidelines (continued from previous page)
G. Tuberculosis Screening	Adults are screened for tuberculosis (TB) risk factors upon enrollment and at periodic physical evaluations. The Mantoux skin test, or other approved TB infection screening test,* is administered to **all** asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they had not had a test in the previous year. Adults already known to have HIV or who are significantly immunosuppressed require annual TB testing.** The Mantoux is not given if a previously positive Mantoux is documented. Documentation of a positive test includes follow-up care (e.g. further medical evaluation, chest x-ray, diagnostic laboratory studies and/or referral to specialist). Practitioners are required to follow current CDC and American Thoracic Society guidelines for TB diagnosis and .treatment. * Per June 25, 2010 CDC MMWR, the FDA approved IGRA serum TB tests, such as QuantiFERON®-TB Gold (QFT-G and QFT-GIT) and T-SPOT®.TB (T-Spot). Ref: www.cdc.gov/tb/publications/factsheets/testingIGRA.htm ** Per CTCA/CDPH: www.ctca.org/guidelines/IIA2targetedskintesting.pdf
H. Breast Cancer Screening	A routine screening mammography for breast cancer is completed every 1-2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated. USPSTF link: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm
I. Cervical Cancer Screening	Routine screening for cervical cancer with Papanicolaou (Pap) testing is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin within 3 years of onset of sexual activity or age 21 (whichever comes first) and repeated at least every 1-3 years depending on individual risk factors. Follow-up of abnormal test results is documented. According to the USPSTF, routine Pap testing may not be required for the following: 1) women who have undergone hysterectomy in which the cervix is removed, unless the hysterectomy was performed because of invasive cancer, 2) women after age 65 who have had regular previous screening in which the smears have been consistently normal. USPSTF link for cervical cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm
J. Chlamydia Infection Screening	Women who are sexually active are screened from the time they become sexually active until they are 25 years of age. Practitioner may screen women older than 25 years of age if the practitioner determines that the patient is at risk for infection. Lab results are documented.
K. Colorectal Cancer Screening	All adults are screened for colorectal cancer beginning at age 50 years and continuing until age 75 years to include: 1. Annual screening with high-sensitivity fecal occult blood testing, **or** 2. Sigmoidoscopy every 5 years with high sensitivity fecal occult blood testing every 3 years, **or** 3. Screening colonoscopy every 10 years. USPSTF link for colorectal cancer screening: http://www.uspreventiveservicestaskforce.org/uspstf/uspscolo.htm
L. Adult Immunizations	
1. Given according to ACIP guidelines	Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member.
2. Vaccine administration documentation	The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
3. Vaccine Information Statement (VIS) documentation	The date the VIS was given (or presented and offered) *and* the VIS publication date are documented in the medical record.

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued on next page)
A. Initial Comprehensive Assessment (ICA)	**Note: Item A.1 assesses the timeframe of a completed ICA. Items A2-9 assess the individual components of the ICA, and can receive a "yes" score - *apart from the timeframe*.**
1. ICA completed within 4 weeks of entry to prenatal care	The ICA was completed within 4 weeks of entry to prenatal care.
2. Obstetrical and Medical History	Obstetric/medical: Health and obstetrical history (past/current), LMP, EDD.
3. Physical Exam	Physical exam: includes breast and pelvic exam.
4. Lab tests	Lab tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen.
5. Nutrition	Nutrition: Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation.
6. Psychosocial	Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources.
7. Health Education	Health education: Language and education needs.
8. Screening for Hepatitis B Virus	All pregnant women are screened for Hepatitis B during their first trimester or prenatal visit, whichever comes first.
9. Screening for Chlamydia Infection	All pregnant women ages 25 and younger, and older pregnant women who are at increased risk, are screened for chlamydia during their first prenatal visit.
B. Second Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 2nd trimester.
C. Third Trimester Comprehensive Re-assessment	Subsequent comprehensive prenatal re-assessments include Obstetric/medical, Nutrition, Psychosocial and Health Education re-assessments are completed during the 3rd trimester.
1. Screening for Strep B	All pregnant women are screened for Group B Streptococcus between their 35th and 37th week of pregnancy.
D. Prenatal care visit periodicity according to most recent ACOG standards	ACOG's *Guidelines for Perinatal Care* recommend the following prenatal schedule for a 40-week uncomplicated pregnancy: • First visit by 6-8th week • Approximately every 4 weeks for the first 28 weeks of pregnancy • Every 2-3 weeks until 36 weeks gestation • Weekly thereafter until delivery • Postpartum visit within 4-8 weeks after delivery If the recommended ACOG schedule is not met, documentation shows missed appointments, attempts to contact member and/or outreach activities.

Rationale: Perinatal assessments are provided according to the current American College of Obstetrics and Gynecologists (ACOG) standards and Comprehensive Perinatal Services Program (CPSP) Guidelines. **RN/MD Review only**

Criteria	VI. OB/CPSP Preventive Reviewer Guidelines (continued from previous page)
E. Individualized Care Plan (ICP)	ICP documentation includes specific obstetric, nutrition, psychosocial and health education risk problems/conditions, interventions, and referrals.
F. Referral to WIC and assessment of Infant Feeding status	Pregnant and breastfeeding Plan members must be referred to WIC (Public Law 103-448, Section 203(e)). Referral to WIC is documented in the medical record (Title 42, CFR 431.635). Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10). **Note:** Although WIC determines eligibility for program participation, nearly all Medi-Cal beneficiaries are income eligible for WIC. Federal regulations specify that pregnant and breastfeeding women are given the highest priority for WIC Program enrollment.
G. HIV-related services *offered*	The ***offering*** of prenatal HIV information, counseling and HIV antibody testing is documented (CA Health & Safety Code, Section 125107). Practitioners are ***not required*** to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. Offering a prenatal HIV test is not required if a positive HIV test is already documented in the patient's record or if the patient has AIDS diagnosed by a physician. **Note:** Member's participation is voluntary. Practitioner may provide HIV test or refer to other testing program/site. Documentation or disclosure of HIV related information must be in accordance with confidentiality and informed consent regulations.
H. AFP/Genetic Screening *offered*	The ***offering*** of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period is documented (CCR, Title 17, Sections 6521-6532). Genetic screening documentation includes: 1) family history, 2) Triple marker screening tests: Alpha Fetoprotein (AF), unconjugated estriol (UE), human chorionic gonadotropin (HCG), 3) member's consent or refusal to participate. **Note:** Member's participation is voluntary. Testing occurs through CDPH Expanded AFP Program, and only laboratories designated by CDPH may be used for testing.
I. Domestic Violence/Abuse Screening	Provision of a Domestic Violence Screening is documented. Assessment checklists, body diagrams and/or documentation in progress notes are acceptable. Domestic violence screening includes medical screening, documentation of physical injuries or illnesses attributable to spousal/partner abuse, and referral to appropriate community service agencies (CA Health & Safety Code, Section 1233.5).
J. Family Planning Evaluation	Family Planning counseling, referral or provision of services is documented (MMCD Policy Letter 98-11).
K. Postpartum Comprehensive Assessment	Comprehensive postpartum reassessment includes the 4 components: medical exam, nutrition (mother and infant), psychosocial, health education are completed within 4-8 weeks postpartum (MMCD Policy Letter 96-01). If the postpartum assessment visit is not documented, medical record documents missed appointments, attempts to contact member and/or outreach activities. Infant feeding/breastfeeding status is documented during the postpartum period (MMCD Policy Letter 98-10).

Attachment B

Medical Record Review Survey

California Department of Health Care Services
Medi-Cal Managed Care

Health Plan_____ **IPA** _____**Site No.**_____ **Review Date** _____ **No. of Physicians** _____ **No. of Records**_____

Provider _____ **Phone** _____ **Fax** _____

Address_____ **Contact person/title** _____

City/Zip Code_____ **Reviewer/title** _____

Visit Purpose	Site-Specific Certification(s)	Provider Type	Clinic type
_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____ (type)	_____ AAAHC _____ JCAHO _____ CHDP _____ NCQA _____ CPSP _____ None _____ Other _____	_____ Family Practice _____ Internal Medicine _____ Pediatrics _____ OB/GYN _____ General Practice _____ Specialist _____ Mid-level (type)_____	_____ Primary Care _____ Community _____ Hospital _____ FQHC _____ Rural Health _____ Other _____ (type) _____ Solo _____ Group _____ Staff/Teaching

Scoring Procedure

Note: Score only one Preventive section (Pediatric, Adult or OB/CPSP) per record. When scoring for OB/CPSP Preventive, do not score the Adult or Pediatric Preventive for that same record**.**

	Points possible	Yes Pts. Given	No's	N/A's	Section Score %
I. Format	**(8) x 10 = 80**				
II. Documentation	**(7) x 10 = 70**				
III. Continuity/Coordination	**(8) x 10 = 80**				
IV. Pediatric Preventive	**(19) x # of records**				
V. Adult Preventive	**(15) x # of records**				
VI. OB/CPSP Preventive	**(20) x # of records**				
	Total Points Possible	**Yes Pts. Given**	**No's**	**N/A's**	

Medical Record Scores

Scoring is based on **10** medical records.

1) Add points given in each section.
2) Add points given for all six (6) sections.
3) Subtract "N/A" points (if any) from total points possible to get "adjusted" total points possible.
4) Divide total points given by "adjusted" total points possible.
5) Multiply by 100 to determine compliance rate as a percentage.

_____ (Points Given) ÷ _____ (Total/ Adjusted Pts. Poss.) = _____ (Decimal Score) **x 100** = _____% (Compliance Rate)

Note: Since Preventive Criteria have different points possible per type (Ped-19, Adult-15, OB/CPSP-20), the total points possible will differ from site to site, depending on the number of *types* of records that are selected. The "NO" column *may* be used to help double-check math. The far right Section Score % column may be used to determine if section is <80%.

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

___**Exempted Pass: 90% or above:** (Total score is ≥ 90% *and* all section scores are 80% or above)

__ **Conditional Pass: 80-89%:** (Total MRR is 80-89% *OR any* section(s) score is < 80%)

__**Not Pass: Below 80%**

__CAP Required

__Other follow-up

Next Review Due: _____

Blank Page (for numbering purposes)

I. Format Criteria

Note: A Format section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. An individual medical record is established for each member.	**1**											
B. Member identification is on each page.	**1**											
C. Individual personal biographical information is documented.	**1**											
D. Emergency "contact" is identified.	**1**											
E. Medical records on site are consistently organized.	**1**											
F. Chart contents are securely fastened.	**1**											
G. Member's assigned primary care physician (PCP) is identified.	**1**											
H. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons are prominently noted.	**1**											
	Yes											
Comments:	No											
	N/A											
	8 **Pts. Possible**											

II. Documentation Criteria

Note: A Documentation section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Allergies are prominently noted.	**1**											
B. Chronic problems and/or significant conditions are listed.	**1**											
C. Current *continuous* medications are listed.	**1**											
D. Signed Informed Consents are present when any invasive procedure is performed.	**1**											
E. Advance Health Care Directive information is offered. (Adults 18 years of age or older; Emancipated minors)	**1**											
F. All entries are signed, dated and legible.	**1**											
G. Errors are corrected according to legal medical documentation standards.	**1**											
	Yes											
Comments:	No											
	N/A											

7
Pts. Possible

III. Coordination/Continuity of Care Criteria

Note: A Coordination/Continuity section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. History of present illness is documented.	**1**											
B. Working diagnoses are consistent with findings.	**1**											
C. Treatment plans are consistent with diagnoses.	**1**											
D. Instruction for follow-up care is documented.	**1**											
E. Unresolved/continuing problems are addressed in subsequent visit(s).	**1**											
F. There is evidence of practitioner *review* of consult/referral reports and diagnostic test results.	**1**											
G. There is evidence of *follow-up* of specialty referrals made, and results/reports of diagnostic tests, when appropriate	**1**											
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	**1**											
	Yes											
	No											
	N/A											

Comments:

8
Pts. Possible

IV. Pediatric Preventive Criteria (continued on next page)

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only Note:

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Assessment (IHA) Includes H&P and IHEBA												
1. History and physical (H&P)	**1**											
2. Individual Health Education Behavioral Assessment (IHEBA)	**1**											
B. Subsequent Periodic IHEBA	**1**											
C. Well-child visit												
1. Well-child exam completed at age appropriate frequency	**1**											
2. Anthropometric measurements	**1**											
3. BMI percentile	**1**											
4. Developmental screening	**1**											
5. Anticipatory guidance	**1**											
6. STI screening on all sexually active adolescents, including chlamydia for females	**1**											
7. Pap smear on sexually active females	**1**											
D. Vision Screening	**1**											

IV. Pediatric Preventive Criteria (continued from previous page)

Note: A Pediatric Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
E. Hearing Screening	**1**											
F. Nutrition Assessment	**1**											
G. Dental Assessment	**1**											
H. Blood Lead Screening Test	**1**											
I. Tuberculosis Screening	**1**											
J. Childhood Immunizations												
1. Given according to ACIP guidelines	**1**											
2. Vaccine administration documentation	**1**											
3. Vaccine Information Statement (VIS) documentation	**1**											
	Yes											
	No											
	N/A											

19
Pts. Possible

Comments:

V. Adult Preventive Criteria (continued on next page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Health Assessment (IHA): Includes H&P and IHEBA												
1. History and physical (H&P)	**1**											
2. Individual Health Education Behavioral Assessment (IHEBA)	**1**											
B. Subsequent Periodic IHEBA	**1**											
C. Periodic Health Evaluation according to most recent USPSTF Guidelines	**1**											
D. High Blood Pressure Screening	**1**											
E. Obesity Screening	**1**											
F. Lipid Disorders Screening	**1**											

V. Adult Preventive Criteria (continued from previous page)

Note: An Adult Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age/Gender	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
G. Tuberculosis Screening	**1**											
H. Breast Cancer Screening	**1**											
I. Cervical Cancer Screening	**1**											
J. Chlamydia Infection Screening	**1**											
K. Colorectal Cancer Screening	**1**											
L. Adult Immunizations												
1. Given according to ACIP guidelines	**1**											
2. Vaccine administration documentation	**1**	y										
3. Vaccine Information Statement (VIS) documentation	**1**	y										
	Yes											
	No											
	N/A											

Comments:

15
Pts. Possible

VI. OB/CPSP Preventive Criteria (continued on next page)

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Initial Comprehensive Prenatal Assessment (ICA)												
1. ICA completed within 4 weeks of entry to prenatal care	1											
2. Obstetrical and Medical History	1											
3. Physical Exam	1											
4. Lab tests	1											
5. Nutrition	1											
6. Psychosocial	1											
7. Health Education	1											
8. Screening for Hepatitis B Virus	1											
9. Screening for Chlamydia Infection	1											
B. Second Trimester Comprehensive Re-assessment	1											
C. Third Trimester Comprehensive Re-assessment	1											
1. Screening for Strep B	1											
D. Prenatal care visit periodicity according to most recent ACOG standards	1											

VI. OB/CPSP Preventive Criteria (continued from previous page)

Note: An OB/CPSP Preventive section score < 80% requires a CAP for the entire MRR, regardless of the Total MRR score.

RN/MD Review only

Criteria met: Give one (1) point. **Criteria not met: 0 points** **Criteria not applicable: N/A** Age	**Wt**	MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
E. Individualized Care Plan (ICP)	**1**											
F. Referral to WIC and assessment of Infant Feeding status	**1**											
G. HIV-related services *offered*	**1**											
H. AFP/Genetic screening *offered*	**1**											
I. Domestic Violence/Abuse Screening	**1**											
J. Family Planning Evaluation	**1**											
K. Postpartum Comprehensive Assessment	**1**											
	Yes											
	No											
	N/A											

Comments:

20
Pts. Possible

MEMBER SERVICES

NOBLE COMMUNITY MEDICAL ASSOCIATES OF MID-ORANGE COUNTY

Member Services

For Member related services, call below Monday-Friday from 8:00AM to 5:00PM:

(714) 947-8600

Additional Member information enclosed to assist with the member's rights:

- Member Complaints, Grievances, and Appeal
- Interpreter Services
- Obtaining Assistance with Cultural and Linguistic Services

NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY

PATIENT RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHTS TO:

1. Dignified, courteous and considerate treatment by all staff
2. To have access to your medical records and have them kept confidential
3. To get information and communicate in the language that works best for you
4. To be informed about all health services that you can get
5. To say "no" to medical treatment
6. To receive preventative health services
7. To know and understand your medical problem and treatment plan
8. To receive an answer from your doctor when requesting special approval(s)
9. If you have an urgent condition, to receive an answer within 24 hours
10. To have a second opinion
11. To know when providers are no longer contract with your health network
12. To receive care from a certified nurse practitioner (CNP) and/or certified nurse midwife (CNM); and
13. To be told about procedures, including the complaint process with your health network and health plan and your right to file a State hearing

YOU ARE RESPONSIBLE FOR:

1. Knowing, understanding and following what is in your health plan's member handbook
2. Following the treatment plan your doctor/Primary Care Provider gives you
3. To tell your doctor/Primary Care Provider about your medical condition
4. To make and KEEP your appointments with your doctor/Primary Care Provider when you are sick, as well as tell your doctor's office when you must cancel your appointment
5. To learn about your medical condition and what keeps you healthy
6. To actively join in health care programs that keep you well; and
7. To be helpful and kind to the people who are partners in your health care

**Please post the following copy in plain view of patients.*

Patient Rights and Responsibilities

YOU HAVE THE RIGHTS TO:

1. Dignified, courteous and considerate treatment by all staff
2. To have access to your medical records and have them kept confidential
3. To get information and communicate in the language that works best for you
4. To be informed about all health services that you can get
5. To say “no” to medical treatment
6. To receive preventative health services
7. To know and understand your medical problem and treatment plan
8. To receive an answer from your doctor when requesting special approval(s)
9. If you have an urgent condition, to receive an answer within 24 hours
10. To have a second opinion
11. To know when providers are no longer contract with your health network
12. To receive care from a certified nurse practitioner (CNP) and/or certified nurse midwife
    (CNM); and
13. To be told about procedures, including the complaint process with your health network and health plan and your right to file a State hearing

YOU ARE RESPONSIBLE FOR:

1. Knowing, understanding and following what is in your health plan’s member handbook
2. Following the treatment plan your doctor/Primary Care Provider gives you
3. To tell your doctor/Primary Care Provider about your medical condition
4. To make and KEEP your appointments with your doctor/Primary Care Provider when you are sick, as well as tell your doctor’s office when you must cancel your appointment
5. To learn about your medical condition and what keeps you healthy
6. To actively join in health care programs that keep you well; and
7. To be helpful and kind to the people who are partners in your health care

HEALTHSMART MANAGEMENT SERVICES, INC.

SUBJECT: Member Rights, Protections and Responsibility Policy# M.S. 7008
DEPARTMENT: Member Services

Effective Date: December 2014
Last Revision Date: May 2015; June 2017; June 2018; May2019; May2020

SCOPE:

This policy applies to Medicare & Medi-Cal lines of business.

PURPOSE:

To ensure members are aware and guaranteed their rights and protections. Member rights include but are not limited to, those rights and protections provided by 42 CFR 438.10, 42 CFR 422 Subpart C and the CFAM-MOU.

POLICY:

All members must be guaranteed their right to the following:

1. Right to be treated with dignity and respect.

2. Right to be afforded privacy and confidentiality in all aspects of care for all health care information, unless otherwise required by law.

3. Right to be provided copy of his or her medical records, upon request, and to request corrections or amendments to these records.

4. Right to not be discriminated against based on race, ethnicity, national origin, religion, sex, age, genetic information or source of payment.

5. Right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

6. Right to access to an adequate network of primary and specialty providers who are capable of meeting the member needs with respect to physical access, and communication and scheduling needs, and are subject to on-going assessment of clinical quality including required reporting.

7. Right to choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.

8. Right to participation in all aspects of care and to exercise all rights to appeal. This includes but is not limited to the right to freely exercise his or her rights without adverse effect on the way a provider or its contractors treat the member.

9. Right to file an Appeal if services are denied that the member feels are medically indicated and to have an independent external system of review.

10. Right to receive medical and non-medical care from a team that meets the member's needs in a manner that is sensitive to the member's language and culture in an appropriate care setting including the home and community.

11. Members have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end.

12. Receive a comprehensive health risk assessment upon date of coverage in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, including an evaluation of the members strengths and weaknesses, and a plan for managing and coordinating the member's care. A member or their designated representative, also have a right to request re-assessment by an interdisciplinary care team, and be fully involved in any such reassessment.

13. Right to be provided information on all programs services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, and in consideration of member's condition and ability to understand.

14. Right to translation of services available to make information appropriately accessible.

15. Right to elect a representative and/or caregiver and/or family member in treatment discussions and decisions.

16. Right to receive advance notice, in writing, of any transfer to another treatment setting and the justification for transfer.

17. Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

18. Right to receive information timely regarding plan changes. This includes but is not limited to, the right to request and obtain information listed in the orientation materials once a year and the right to receive notice of any significant change in the information provider in the orientation materials at least 30 days prior to the intended effective date of a change.

19. Right to be protected from liability for payment of any fees that are the obligation of the plan or Medical Group which the member is assigned.

20. Right to not be charged any cost sharing for Medicare Part A and B services, when applicable. Members shall not be balanced billed by provider. If provider balance bill member, provider will be contacted and educated to not balance bill member. Provider will also be mailed a letter notifying them of the guidelines of balance billing members.

21. The unconditional and exclusive right to hire, fire, and supervise his or her In Hone Support Services provider, where applicable.

22. Right to receive their Medicare and/or Medi-Cal appeals rights in a format and language that is easily understood and accessible.

23. For CalMediConnect members, the right to opt out at any time, beginning at the first of the following month.

REFERENCES
A. Title, 42, CFR 483.100, 42 CFR 422 subpart C, CFAM-MOU

HEALTHSMART MANAGEMENT SERVICES, INC.

SUBJECT: Member Grievances & Appeals # MS 7010
DEPARTMENT: Member Services

Effective Date: July 2006
Last Revision Date: **May 2014**
Last Revision Date: May 2015, May 2026
Last Review Date: June 2017; June 2018; April 2019; May 2020, August 2021, August 2023, July 2024, May 2025, May 2026

PURPOSE: To define the process by which Health Network addresses and resolves grievances from Members, Whole Child Model Members or Member Representatives for those persons enrolled according to the applicable legislative, regulatory and contractual requirements.

SCOPE: All Lines of Business

POLICY:

IPA shall establish and maintain a Grievance Process in which members may submit complaints for review and resolution.

The grievance process will address the receipt, investigation, and resolution of Member Complaints and grievances according to statutory, regulatory and contractual requirements.

PROCEDURE

A. Member Complaints / Appeals from Health Plan

1. When a written Member Complaint or Appeal is received from the Health Plan the Member Services Rep. is to:

   - Contact the Provider's office or department to let them know that you are faxing a Member Complaint/Appeal received from the Health Plan for a written response from the provider's office.

   - Let the Provider's office know that they need to respond to the complaint/appeal and submit any requested information by the due date. Inform the provider's office that response and requested documents needs to be sent back to the Member Services Rep. that initiated the process.

   - The Member Services Rep. will follow-up with provider every other day to check status on grievance response and to ensure timely submission.

   - If provider does not respond to grievance in a timely manner or refuses to submit a response, the designated representative will:

     a. Advise department Manager. Manager will contact provider office to assist & discuss

the requirements of responding to member grievance.

b. Provider Services will be notified of provider being non-compliant. Provider Services will than call provider to discuss the submission of the grievance response.

- The Member Services Rep. will forward the response & requested documents to the Health Plan.

2. Member Services Rep. must immediately log and record all Complaints/Appeals in the Member Services Tracking log posted on the "MSC" drive & Members Communication Log.

3. Member Services Rep. is responsible for tracking and following up with the Provider's office on the Member Complaint, until a written response and the requested information is received and forwarded to the Health Plan.

4. Once the Member Complaint is resolved and the Resolution Letter is received from the Health Plan; Member Services Rep. must scan & attached to members file. Hard copies are filed in binder.

5. CalOptima may identify a Potential Quality Issue. A PQI shall be identified by utilizing mechanisms such as a concurrent utilization review process, case management process, grievances, or encounter data evaluation.

B. Form of Complaint

1. A member may submit a complaint /appeal via telephone or in writing to the Health Plan directly. If the member calls or submits a written complaint /appeal to the Health Network, instead of the Health Plan, the Member Services Rep. is to:

- Document complaint/appeal in log and forward the complaint via fax or secured e-mail to CalOptima Grievance Department. The Health Network must forward complaint upon receipt of member grievance the same day.

- Member Services Department will promptly assist members with grievance or appeal by documenting on the Member Complaint Form in communication log or by Warm Transferring member to CalOptima Member Services Dept. at **(877) 412-2734 for** OneCare members and **714 - 846-8500** for Medi-Cal members.

- The Lead of the Member Services Department will fax the member complaint form or send a secure e-mail to CalOptima grievance department. **Fax# (714) 246-8562** or secured E-mail at: grievancemailbox@caloptima.org

- The Lead of the Member Services Department will scan a copy of the e-mail or the fax confirmation and attached documents to member's file for records.

- Member grievance & Warm Transfer of member will be documented on tracking log located on the "MSC" drive and member communication log.

DEFINITIONS

Complaint: An Oral or written statement from a Member or Member's Personal Representative, that expresses dissatisfaction with any portion of the health care network. All complaints will be treated as grievances.

Grievance Process: The process by which the IPA addresses and resolves all complaints.

Personal Representative: A person granted legal authority to make health care decisions for adults, emancipated minors, or a parent and guardian of minors.

Appeal: A request for reconsideration of a UM decision to deny or modify a request for services based on medical necessity.

ATTACHMENTS

Member Complaint Form



Member Complaint Form

MEMBER INFORMATION

Member Name: _____ Member ID card number: _____

Street Address: _____City, State and Zip: _____

PCP: _____ Date: _____

NATURE OF COMPLAINT

Problem with doctor or staff ☐	Problem getting appointment/s ☐	Bill received for medical services ☐
Problem getting a referral ☐	Problem getting medicine/prescription ☐	Problem with medical care ☐
Office/facility problem ☐	Other ☐	Appeal ☐

INFORMATION ABOUT THE COMPLAINT

Date of incident: _____

Describe what happened (list the names of those involved)

_____
_____
_____
_____
_____
_____
_____

INFORMATION ABOUT PARTY COMPLETING THIS FORM

Person Making Complaint:

_____
(Print Name)

_____
(Signature of Person Completing this form)

Relationship and Phone# _____

DOCTOR INFORMATION

Doctor Name: _____ Date of last visit: _____

Address: _____

City: _____ Phone Number: _____

Member complaints must be sent over to CalOptima the same day via fax and or by secured e-mail. Fax # (714) 246-8562; Grievancemailbox@caloptima.org

HEALTHSMART MANAGEMENT SERVICES ORGANIZATION, INC.

2026 CULTURAL & LINGUITICS PLAN

I. INTRODUCTION:

The Cultural & Linguistics Plan includes the concepts of effective service delivery that address culture, language access and disability-related access and are integrated into training and quality service monitoring.

II. GOALS AND OBJECTIVES:

The Cultural & Linguistics Plan exists to ensure the delivery of culturally competent services and ensure the provision of Linguistic Access and Disability-related Access. The plan describes how the individuals and systems within the provider networks will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individual and protects and preserves the dignity of each.

III. POLICY

The Cultural & Linguistics Plan includes policy direction relating to the provision of culturally competent service, access to language services (including sign language), access to services for patients with special needs, and translation of written materials. The plan also includes policy direction related to monitoring of Cultural Competency through the Continuing Quality Improvement Processes that exist in the provider networks, language service inventory and competency. Providers are required to maintain evidence of bilingual capabilities of providers/staff.

For translation of vital documents [i.e. denial letters, etc.] the member will be referred to their health plan for assistance.

IV. SCOPE:

Training and monitoring of employees and provider networks are the cornerstones of successful culturally competent service delivery. For that reason, the program is integrated into the overall employee and provider training and quality monitoring programs. Such an integrated quality approach is aimed at enhancing the way people think about patients, service delivery and program development so that cultural competency becomes a part of everyday thinking. Quality monitoring programs touch all parts of the organization and network. Cultural competency is a key quality component.

V. PROGRAM COMPONENTS

EMPLOYEE TRAINING

Employee training is conducted upon hiring with annual reinforcement integrated in modules delivered through a variety of methods including, but not limited to one or more of the following:

- Written materials
- Employee communications
- Enduring reference materials
- Integration of cultural and linguistically appropriate service concepts in recurring staff meetings
- Training and monitoring concurrent with other skills included in the job description of each position

General cultural competency training is provided to all employees, while additional training is provided according to needs determined by each employee's job description, level of interaction with members or providers. For example, Train-the-Trainer programs for provider service representatives are conducted for individuals that will in turn train providers. Health Plans also offer training programs.

PROVIDER AND COMMUNITY TRAINING

Cultural Competency Programs are offered to employees, providers and staff supporting providers as well – in short, anyone that may interact with a member. Cultural Competency Training programs will be made available to Community Based Organizations as well.

Provider training is conducted concurrent with and integrated into provider orientation with annual reinforcement training. Additional training reinforcement accompanies any continuing medical education programs developed by the organization and periodically accompanying provider communications.

Training is provided in modules delivered through a variety of methods including, but not limited to one or more of the following:

- Written materials – Provider Manual
- Access to reference materials available through the organization
- Integration of cultural competency concepts into provider communications
- Programs offered by the Health Plans.

INTEGRATED QUALITY IMPROVEMENT PROCESSES

The application of the concepts of cultural competency includes ensuring member access to language services such as interpreting, written translation as well as access to programs and services that are congruent with cultural norms. Such congruency with member populations leads to better communication, understanding and member satisfaction.

Cultural Competency elements will be included in the overall Quality Improvement monitoring structure applied by the organization. These include but are not limited to monitoring of the quality of Human Resources, Member Services, Provider Services, Contracting, Credentialing, and Case Management.

VI. EVALUATION

The Quality Management Committee will complete an annual evaluation of the Cultural and Linguistics Work Plan. This review will include, issues resulting from any grievance monitoring, findings of the Member Satisfaction Survey as they relate to Cultural & Linguistics services, annual survey of the languages spoken in the provider offices and resource assessment as applied to health education and disease management programs.

VII. CONFIDENTIALITY

All staff participating in quality service and cultural and linguistic monitoring activities shall be required to sign a confidentiality agreement. The agreement will be maintained in the employee's file.

SUBJECT: Cultural & Linguistics Service Standards & Monitoring **Policy:** QM.14
DEPARTMENT: Quality Management

Effective Date: February 2005
Last Revision Date: November 8, 2012
Last Review: January 2021

SCOPE:

This applies to all lines of business.

PURPOSE

To ensure effective communication regarding treatment, diagnosis, medical history, and health education by providing cultural, linguistic, and sensory appropriate services for all Members, taking into consideration Members' beliefs, traditions, customs, and individual differences.

POLICY:
IPA shall provide culturally and linguistically appropriate services to Members. Specifically, they shall:

1. Recruit bilingual employees for appropriate positions whenever possible, and enhance employees' bilingual skills and cultural sensitivity through employee development programs, as needed;

2. Provide twenty-four (24) hour access to interpreter services, including sign language interpreter services, at Key Points of Contact for all Members;

3. Provide translations of informational materials in Threshold Languages and meet the needs of Members with sensory impairments ; and ensure materials will be at a 5th grade or less reading level.

4. Refer a Member to culturally and linguistically appropriate community services, as needed.

5. Maintain evidence of bilingual capabilities of the provider and staff.

6. The IPA will adjust the network if necessary based on the cultural & linguistic needs of its members.

7. The IPA will send a C&L referral activity report to the Health Plan according to the report timeliness requirement of the Health Plan.

To facilitate the development of programs and services, IPA shall collaborate with health plan partners to identify health education and cultural and linguistic needs by conducting a Group Needs Assessment (GNA) every three (5) years. In addition, the IPA will perform and annual assessment of Provider Office language capabilities. This may be done through a Provider Survey, on-site visits and during the credentialing process.

IPA shall develop a C&L policies and procedures and shall designate a professional to be responsible for activities conducted under the policies and procedures.

IPA shall collaborate with the health plans to assess the bilingual proficiency of a provider that lists bilingual capabilities, and shall submit results of such assessment as specified by health plans.

IPA shall monitor complaints and grievances and report complaints and grievances related to C&L services to the health plans.

DEFINITIONS:

California Relay Service: A telecommunications relay service, which provides full telephone accessibility to people who are deaf, hard of hearing or speech disabled available 24 hours a day, 365 days a year with no restrictions on length or number of calls placed. There is no charge for using the service within your local call area. Specially trained Communications Assistants complete all calls and stay on-line to relay messages electronically over a text telephone (TT), so called TTY for "Teletype" or verbally to hearing parties.

Concentration Language: More than 1000 members with the specified language.

Cultural and Linguistic (C&L) Services: Services to Members that include the hiring of bilingual and culturally sensitive personnel; providing interpreter services both in person and over the telephone, including signage; providing Members with translated materials; and referring Members to culturally and linguistically appropriate services.

Cultural Competency: The ability of health professionals to actively apply knowledge of cultural behavior and linguistic issues when interacting with Members from diverse cultural and linguistic backgrounds. The essential elements of cultural competency are:

1. An unbiased attitude that values and respects cultural diversity; a respect for the multifaceted nature and individuality of people;

2. Awareness that culture and cultural beliefs may influence health and health care delivery;

3. Recognition of the diversity among Members;

4. Skills to communicate effectively with diverse populations and applications of those skills in cross-cultural interactions to ensure equal access to quality health care;

5. Knowledge of disease prevalence in specific cultural populations, whether defined by ace, ethnicity, socio-economic status, physical or mental ability, gender, sexual orientation, age, or disability.

Emergency Medical Condition: A medical condition that is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of hea1th and medicine could reasonably expect the absence of immediate medical attention to result in:

1. P1acing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

Group Needs Assessment (GNA): An evaluation performed to identify the health education, linguistic and cultural needs of IPA Members, including those groups whose primary language are non-English, for the purpose of deve1oping programs and services.

Key Points of Contact: Service sites that provide Members with access to health care services, both medical (urgent care or face-to-face encounters with providers) and non-medical (Member services, appointments or orientation meetings).

Limited English Proficient (LEP): Members who cannot speak, read or write or understand the English language at a level that permits them to interact effectively with health care providers.

Threshold Languages: Languages spoken by the Limited English Proficient (LEP). The Threshold Languages are determined by the health plans in accordance regulatory agencies.

Urgent Care: Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e. sore throat, minor lacerations, and some broken bones.

PROCEDURE:

A. Group Needs Assessment (GNA)

1. IPA shall assign a professional to collaborate in conducting the GNA. This staff shall be responsible for coordinating with health plan staff to implement effective health education programs and cultural and linguistic programs resulting from the GNA and for reporting on the GNA and related activities, including annual survey of provider office bilingual capabilities to the IPA Quality Improvement Committee as required.

2. IPA shall provide input to the health plans in development of a C&L services plan and assist in the identification of resources needed for the implementation of health education initiatives.

3. The IPA will perform and annual assessment of provider office language capabilities. This may be done as part of the annual provider survey, a separate language capability survey, on-site visits and during the credentialing process.

B. Employee Recruitment and Development

1. IPA shall make best efforts to recruit qualified culturally sensitive and bilingual employees, especially for positions that require direct Member communication.

2. IPA shall assess the language capability of an employee to determine the employee's proficiency level for an assignment that includes the use of bilingual skills.

3. IPA shall enhance an employee's ability to communicate managed care and medical care terminology to a Member in such Member's native language through training and development programs.

4. IPA shall provide comprehensive staff training to ensure a Member with a sensory impairment is assisted in accessing information, services, and benefits.

5. IPA shall encourage employees to attend cultural sensitivity seminars and workshops offered by health plans, professional organizations, universities, or colleges in order to develop Cultural Competency including but not limited to:

   a. Developing attitudes that value and respect diversity;

   b. Enhancing knowledge and awareness of beliefs, behaviors, and preventive health practices;

   c. Acquiring skills to communicate with Members with diverse language needs, including sign language interpreter services; and

   d. Developing the ability to address the health needs of diverse populations.

C. Interpreter Services and Access for Members with Sensory Impairments

1. IPA shall provide Members with FREE linguistic interpreter services, sign language interpreter services, and information about the California Relay Service (CRS) to Members with hearing impairments and auxiliary aids for Members with visual impairments, as necessary to ensure effective communication regarding treatment, diagnosis, medical history, or health education. (See P&P QM.15: Interpreter Services)

2. The IPA will make a good faith effort to supply materials in alternate format, ie. Audio, Braille, Large Print, etc.

D. Translation Services

1. IPA shall provide informational materials translated in Threshold Languages including, but not limited to the Welcome packet, newsletters, outreach flyers and brochures, consent forms, grievance forms, selection form instructions, and health education materials. In addition, for those documents not available in other languages that may be required, IPA shall arrange for oral translation.

2. To ensure the quality of the translation, IPA shall select qualified translators to translate the documents and submit the document for final approval from the health plan prior to distribution to members.

    - Health Education materials and NOA letters will be the health plans pre-approved materials and letters.

3. When translation service is requested to a Health Plan, all requests will be logged and monitored by the C&L Coordinator. The log will include:

    - Date and time the request for translation or vital document was received;
    - Date and time the member request and/or vital document was forwarded to the Health Plan;
    - Any attachments that are provided with the letter to the member including but not limited to clinical guidelines or medical policy.

4. Requests related to urgent healthcare services will be forwarded within one business day of receipt of request. Requests related to non-urgent healthcare services will be forwarded within two business days of receipt of request.

E. Referral to Culturally and Linguistically Appropriate Services.

1. IPA shall maintain a listing of community-based and faith-based organizations and shall refer members for psychosocial and other culturally and linguistically appropriate community services, as needed.

2. PCPs or Members may self-refer to community based and faith-based organizations as needed.

3. If a PCP needs assistance in locating a special service or program, the PCP may contact the MSO C&L Coordinator or submit via a standard referral request. The C&L Coordinator will locate program, document the request and communicate back to the PCP.

4. Referrals to community based and faith-based organizations are logged as received.

5. As part of care planning, a nurse Case Manager may recommend community based programs to members. The CM nurse will document referral and whether the member actively participates in the recommended program.

F. Monitoring and Evaluation of Cultural and Linguistic Services

1. The IPA will ensure members are provided with culturally and linguistically appropriate services by monitoring and evaluating the following:

    a) All members who have formally requested face-to-face interpreting assistance provided by an Interpreting Service will be included in the annual Member Satisfaction Survey to assess their knowledge and satisfaction with Interpreting Services.

    b) An annual survey will be completed to identify the providers Health Education Material needs and languages needed.

    c) An Annual survey will be performed of the language spoken in the PCP office by the Physician and Staff, including a self-assessment of their proficiency in the language spoken. The IPA will maintain an updated log of languages spoken in the Provider's offices, listing by Physician and Staff.

    d) The IPA will collaborate with the health plans to assess the proficiency of the Providers and Key Point of Contact who are bilingual. The IPA shall submit the results of such assessments to health plans as required by the health plans.

    e) The Provider Facility Site Review, [performed by the Health Plan], assess the provider's compliance with documentation and evidence of Health Education materials in required topics, referrals to community-based programs, and documentation in member's file, and posting of FREE interpreting services sign. Any identified areas of non-Compliance with corrective action reported by the Health Plan will be reported to the QI Committee, assistance with corrective action may be requested and review of final compliance will be assessed.

    f) The provider's will receive updated community resource lists.

    g) IPA shall provide initial and continuing training to contracted providers on Cultural Competency issues. IPA may conduct training in conjunction or collaboration with health plan or work with community organizations or educational institutions to provide the training.

FORMS:

Request/Refusal Form for Interpretive Services

REFERENCES:

Policy and Procedure:

MS.1 Member Grievances
PR.1 Provider Grievances

Title 45, code of Federal Regulations, Section 84.52

SUBJECT: Interpreter & Translation Services **Policy #:** QM15
DEPARTMENT: Quality Management - Cultural Linguistics

Effective date: October 10, 2001
Last Revision date: July 11th, 2024
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure all limited English proficient and Hearing-Impaired members are provided FREE language assistance. To provide a mechanism to ensure efficient communication and access for its members who have specific language needs at Key Points of Contact, 24 hours a day, 7 days a week so members can make informed health decisions. Types of Interpreting Services available are face-to-face, telephonic and/or California Relay Service for Hearing Impaired.

POLICY:

Both translation and interpretation enable communication across languages from source to target. Translation deciphers the meaning of the written word from one language to another. Interpretation conveys the meaning of the spoken word from one language to another.

Providers are required to maintain evidence of bilingual capabilities of providers/staff.

Each PCP office is required to post a sign that FREE Interpreting Services are available upon request; and are provided in all threshold languages. (See attached sign distributed from LA Care).

Interpretive services may be used in medical and non-medical points of contact.

If a Provider's office cannot identify a member's language, they may use "point to" cards or may contact the Member Services Department (714) 947-8600 for assistance.

Providers are given a grid showing process for Interpreting Services according to the health plan the member is assigned, including the contact number for HealthSmart Member Services Department.

IPA shall utilize a vendor for telephone interpretation services for languages not covered by employees or for Urgent Care and Emergency Services; however, face-to-face interpretation is preferred.

The provider will utilize the "Interpreting Services Grid" for reference of Interpreting Services available by plan. This grid is updated at a minimum annually and disseminated to all P&Ps.

Face-to-face interpreter services, including sign language interpreter services, may be scheduled through a contracted vendor or an interpreter who is on "on-call" status.

Interpreting services will be offered FREE to all members with any specific language needs.

Members will not be charged any fee for interpreting services.

All reasonable efforts will be made to provide an interpreter in time to adequately assist with all necessary care, including Urgent Care and care for an Emergency Medical Condition.

Members have the right to file a complaint if they fail to receive requested interpreting services or are unsatisfied with the interpreting services provided.

If a provider office identifies a member as being limited English proficient and the member is already at the office, telephonic interpretation should be used immediately to avoid any delay in service.

Providers shall utilize Telecommunications Device for the Deaf (TDD), the California Relay Service (CRS), or a comparable device or service available to assist a Member with a hearing impairment.

For a member with a visual impairment, the Providers will utilize informational or educational materials, available in the Threshold Languages.

The IPA will provide, at no cost to the member, written materials such as provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, in non-English languages or accessible formats.

Required materials and content will be provided to members on a standing basis in any non-English language or accessible format when a request is received by the member, or the IPA otherwise learns of the member's need for an alternate format.

Required materials and content will be translated into any non-English language that is the primary language of at least 5% of the members in a plan benefit package service area.

All requested translated materials will be sent to the member within the regulatory timeframes.

The IPA will make a good faith effort to supply materials in alternate format upon request. Alternate formats include but is not limited to Audio, Braille, Large Print [no less than 20 Arial Font for visually impaired], accessible format, such as data CD, as well as requests for other auxiliary aids and services that may be appropriate. Special request needs will be documented for future needs and reported as required by Health Plans.

If a member selects an electronic format, such as an audio or data CD, the information may be provided unencrypted but only with the member's informed consent. The member will be contacted regarding alternate format, that unless the member requests a password protected format, the member will be receiving notices and information in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Members may request notices and information in a password protected electronic format and must provide separate unencrypted instructions on how the member is to access the encrypted information.

Members who state they have difficulty reading print communications on account of a disability must be notified of their right to receive auxiliary aids and services, including alternate formats.

Auxiliary aids and services must be provided to a family member, friend, or associate of a member if required by the ADA, when said member is identified as the member's authorized representative or is someone whom it is appropriate to communicate with (i.e., a disabled spouse of a member).

Alternate format needs shall not be reduced or terminated without adequate notice in required timeframes explaining reason for action and including appeal information.

If the provider identifies a member with this need and does not have the materials needed on site, he may contact the Health Education Coordinator (need telephone #) to obtain required information.

The Providers office will document member's request or refusal of interpreting services, including language spoken.

The Providers office will not require a family member or friend to act as interpreter for a member to be seen.

The Provider will follow the interpreting service grid by the member's corresponding health plan to determine the process for obtaining interpreting services.

The Provider shall not require a Member to use friends or family as interpreters. A Member's friends or family may be used as interpreters if the following conditions are met:

a. It is requested by the Member.

b. It will not compromise the effectiveness of the service.

c. It will not violate the Member's confidentiality; and

d. The Member is advised that an interpreter is available at no cost.

After offering Interpreting Services, if the member would prefer to use a family member or friend, the provider must document in the medical chart the member's refusal of outside service and document name and relationship of interpreter being used.

Providers are prohibited from using minors to interpret.

HealthSmart's Member Services Department may also receive phone calls from LEP members.

A list will be kept of all languages spoken within HealthSmart and the qualifications of each employee within the language spoken. HealthSmart will ensure a self-assessment survey is completed for all bilingual employees and kept on file, until such a time the health plan provides a formal mechanism for assessment.

If HealthSmart receives a phone call and does not have an employee proficient in the member's identified language, HealthSmart will contact the member's corresponding Health Plan to be connected to the AT&T Language Line.

When telephonic Interpreting Services are required, the providers will contact HealthSmart's C&L Coordinator who will assess eligibility and begin the process according to the member's health plan.

The member's corresponding health plan will connect with their AT&T Language Line to assist in communicating with the member.

A roster of all contracted providers, the languages spoken by the physician and the language spoken by the staff will be made available to all Primary Care Providers, the Medical Directors, and HealthSmart Staff. This list will be updated annually. The list will be used to assist in direction to specialty providers for members with language specific needs, however the member still has the right to request an interpreter.

A list of all languages spoken by HealthSmart employees will be updated annually and maintained.

The Referral Authorization Worksheet will contain an area to identify the member's primary language.

All attempts will be made to ensure that the primary language of the member is spoken within that referral service or specialty office. However, the provider and members can still request an interpreter to attend.

When requesting a face-to-face interpreter to assist in consultation with a specialty provider or service, the provider will circle Interpreting Assistance and enter the member's language need.

Setting up an interpreter will not delay the approval of service; however, time should be allowed to set up a face-to-face interpreter.

In cases where the member and/or provider requests an interpreter to attend an appointment with the member (face-to-face), the provider will contact the C&L Coordinator in advance for this service.

In some cases where coordination is to occur through the health plan, 5-7 days notice may be required.

When possible, a Provider shall ensure the assignment of the same interpreter to a Member who requires follow-up care.

In cases where the health plan is responsible for providing this service, the health plan may require a request form to be submitted prior to setting up the service.

In the case where HealthSmart uses its contracted provider, notice is also required to set up the face-to-face interpreter.

If services are needed urgently, then a telephonic interpreter will be utilized.

The C&L Coordinator will keep a log of Interpreting services coordinated and follow up to confirm. The C&L Coordinator will also log into the system the member's need, service provided and by whom for any future needs.

The providers and staff will be notified of Cultural Competency Training programs and encourage provider offices to attend.
Materials interpreted by HealthSmart will have a signed attestation for each document that is translated by a qualified vendor or staff.

The IPA will maintain a list of all translated documents that are obtained from the health plan.

DEFINITIONS:

Cultural and Linguistic Services – Services to members that include the hiring of bilingual and culturally sensitive personnel; providing interpreter assistance both in person and over the telephone, including sign language interpreter services; providing members with translated and/or other materials to meet the needs of sensory impaired members; and referring members to culturally and linguistically appropriate services.

Limited English Proficient – (LEP): members who can not speak, read or write or understand the English language at a level that permits them to interact effectively with health care providers.

Threshold Language – Language spoken by Limited English Proficient members. The threshold languages are determined in accordance with the Department of Health Services guidelines.

California Relay Service – A telecommunications relay service, which provides full telephone accessibility to people who are deaf, hard of hearing or speech disabled available 24 hours a day, 365 days a year with no restrictions on length or number of calls placed. There is no charge for using the service within your local call area. Specially trained Communications Assistants complete all calls and stay on-line to relay messages electronically over a text telephone (TT), so called TTY for "Teletype" or verbally to hearing parties.

PROCEDURE:

A. All Providers will be sent a sign to place in their office informing members of the availability of Interpreting Services. The sign will be posted in plain view for all members to see. Signs may be copied and put in each exam room if the provider chooses.

B. If a member refuses an Interpreting Service and prefers a friend or family member to interpret for them, the Provider and/or will ensure that this is documented in the member's file, including language requested.

C. At each visit the member will be offered interpreting service, even if they have refused in the past. The provider will continue to document any member refusal for interpreter service at each occurrence of refusal of service.

D. If the HealthSmart Member Services Department requires assistance to or from a member with specific language need or is requested to assist in obtaining language line services during business hours, they will follow the following procedure:

1. Place the call on Conference hold using the "Phone conference" feature. Place the non-English speaker on hold by pressing the "Conf" button.

2. Call the corresponding health plan's Member Services Department (See attached List) or AT&T Line.

3. Provide the following information:
    a. Organization name
    b. Client Name and ID Number
    c. Personal Staff Codes
    d. Specific Language required.

4. Wait for the Language Line Operator to conference the Interpreter.

5. Brief the interpreter on the nature of the call and what you want to accomplish.

6. Add the non-English speaker to the line by pressing the Conference feature to connect the caller.

7. Confirm that the Interpreter and the Member or Provider can hear one another.

8. Say "End of Call" to the Interpreter when the call is completed.

9. Document the call.

E. If the request for a face-to-face interpreter is made by telephone and/or as part of a referral service, the provider will need to contact the C&L Coordinator and provide the following in order to set up:
   1. Provider Name and telephone number & Contact person
   2. Language need of member (including American Sign Language)
   3. Patient Information (Name, gender, DOB, assigned health plan, etc.)
   4. Date and time of appointment and estimated duration needed.
   5. Location and type of Appointment
   6. Any Special instructions or considerations.

F. If the request came along with a Referral Authorization Request, the referral authorization will be obtained first, then all paperwork forwarded to the C&L Coordinator. The C&L Coordinator will coordinate with all parties to set up the service, will log, then follow up with all parties to ensure that the Interpreting Services occurred, and satisfaction noted.

G. If a Provider needs to contact a member who is hearing impaired, the Provider will contact the California Relay Service by calling 1-888-577-5379. A Communications Assistant will request the area code and telephone number of the person you wish to contact. The provider is encouraged to speak as if he is talking directly to the patient, saying "Go Ahead" after completing each sentence. (Avoid saying, "tell him "Or "tell her"). The Communications Assistant will type everything you say to the member. This includes any side conversations, background noise, etc.

H. If at any time a Provider, HealthSmart staff member cannot identify a member's language, a phone call will be placed to the member's corresponding Health Plan to connect with a Language Line to assist.

I. If after hours Interpreting Services are required for a telephone call that was placed to HealthSmart, the Answering Service will connect to the AT&T Language Line by following #D-4 above. If necessary, the service may contact the on-call coordinator for HealthSmart. All providers will have a plan in place for after hour's calls, which will also address Language Line needs.

J. The C&L Coordinator will keep a log of C&L related activity in the C&L Binder. All C&L related activities will be noted in the member's eligibility file to ensure that services are consistently set up to meet member's specific language need.

K. Any materials requiring translation will be forwarded to the regulatory agencies for review prior to distribution.

FORMS:

Referral Authorization Worksheet
LA Care FREE Interpreting Assistance notice.
UHP Healthcare FREE Interpreting Assistance notice.

REFERENCES:

Title 28, Code of Federal Regulations, Section 35.160
Title 45, Code of Federal Regulations, Section 84.52

Health Plan Interpreter Services

Health Plan	Telephone Interpretation	Face to Face Interpretation	Protocol for requesting Interpretation Services
Anthem Blue Cross	Member Service at (888) 285-7801	Member Service at (888) 285-7801	**CALL 24 HOURS A DAY, 7 DAYS A WEEK OR FACE TO FACE – NO LESS THAN 5-7 DAYS IN ADVANCE** Please provide the following information 1. Provider Name & Phone number 2. Contact Person 3. Language requested 4. Patients Name & ID # 5. Patient Gender 6. Date, Time and Type of Appointment 7. Duration of Appointment 8. Location of Appointment 9. Other special instructions (i.e patient has disabilities, etc.)
Care 1st Health Plan	Member Service at (800) 605-2556	Member Service at (800) 605-2556	**CALL 24 HOURS A DAY, 7 DAYS A WEEK OR FACE TO FACE – NO LESS THAN 5-7 DAYS IN ADVANCE** Please provide the following information 10. Provider Name & Phone number 11. Contact Person 12. Language requested 13. Patients Name & ID # 14. Patient Gender 15. Date, Time and Type of Appointment 16. Duration of Appointment 17. Location of Appointment 18. Other special instructions (i.e patient has disabilities, etc.)
LA Care Health Plan	Telephonic Interpretation Services (888) 452-2273	Do Not Provide Face to Face Interpretation Send Referral to HealthSmart UM Department	Please provide the following information to Member Service and they will assist you with this service 1. Provider Name/Caller Name 2. Product Line 3. Member First & Last Name 4. Date of Birth 5. IPA Affiliation
Health Net Health Plan	Language Line Service (800) 874-9426	Do Not Provide Face to Face Interpretation Send Referral to HealthSmart UM Department	Please provide the following information to Member Services and they will assist you with this service. 1. Provider Name/Caller name 2. Patient ID # 3. Member First & Last Name 4. Date of Birth
Molina Health Plan	Member Services (888) 665-4621	Health Education Department (800) 526-8196 ext 7532 FAX # (562) 901-1176	**CALL 24 HOURS A DAY, 7 DAYS A WEEK OR FACE TO FACE – NO LESS THAN 5-7 DAYS IN ADVANCE** Please complete attached referral and fax to (562) 901-1176 or please provide the following information to Health Education Representative 1 .Provider Name & Phone number 2. Contact Person 3. Language requested 4. Patients Name & ID # 5. Patient Gender 6. Date, Time and Type of Appointment 7. Duration of Appointment 8. Location of Appointment 9. Other special instructions (i.e patient has disabilities, etc.)

Type of Service	Policy &Procedures
Interpreter Services **(*Language Line*)**	1. A member may call and request interpreter services; such as Language, Face-to-Face interpreter services or Sign Language interpreter services. • HSMSO language services are provided by Language Line: Tel: 1-877-261-6608. 2. Staff is to assist the member with interpreter request. • Conference call member with Language Line to assist member with telephone call. **Procedure:** 1. Place the call on Conference hold using the "Phone conference" feature. Place the non-English speaker on hold by pressing the "Conf" button. 2. Provide the following information: a. Enter Client ID# (See attachment) b. Company Name: c. Press 1 for Spanish or 2 for all other languages 4. Wait for the Language Line Operator to conference the Interpreter. 5. Brief the interpreter on the nature of the call and what you want to accomplish. 6. Add the non-English speaker to the line by pressing the Conference feature to connect the caller. 7. Confirm that the Interpreter and the Member or Provider is able to hear one another. 8. Say "End of Call" to the Interpreter when the call is completed. 9. Document the call
California Relay Service	1. If provider or staff needs to contact a member who is hearing impaired, provider /staff will contact California Relay Service, by doing the following: Dial a voice CA at: 711 (select #9 than dial 711): or call: 1-800-735-2922 (English) 1-800-855-3000 (Spanish)

Access Interpreter Service

A member may call and request interpreter services; such as Language, Face-to- Face interpreter services or Sign Language interpreter services.

- HSMSO language services are provided by Language Line: Tel: 1-877-261-6608.
- Staff is to assist the member with interpreter request.
- Conference call member with Language Line to assist member with telephone call.

Procedure:

1. Place the call on Conference hold using the "Phone conference" feature. Place the non-English speaker on hold by pressing the "Conf" button.

2. Provide the following information:

   a. **Enter Client ID# (See attachment)**
   b. Company Name:
   c. Press 1 for Spanish or 2 for all other languages

3. Wait for the Language Line Operator to conference the Interpreter.

4. Brief the interpreter on the nature of the call and what you want to accomplish.

5. Add the non-English speaker to the line by pressing the Conference feature to connect the caller.

6. Confirm that the Interpreter and the Member or Provider is able to hear one another.

7. Say "End of Call" to the Interpreter when the call is completed

Face to Face and Sign Language Interpreter is scheduled through Language Line based on members scheduled appointment; which usually requires a 5-7 day notice.

Access to TDD/TTY

California Relay Service

- If provider or staff needs to contact a member who is hearing impaired,
- provider /staff will contact California Relay Service, by doing the following:
- Dial a voice CA at: 711 (select #9 than dial 711):

Or can call

1-800-735-2922 (English)

1-800-855-3000 (Spanish)

After Hour Call Service

For After-hours coverage, the Network and MSO will have an Answering Service or process to contact designated employees for urgent calls via pager/cell phone. Any Utilization Outpatient or Inpatient authorization activity will be directed to the IPA's Medical Director for approval and/or direction. Only a physician will give medical advice. All After-Hours calls will be logged and followed up on the next business day.

The After- hour service is called on a daily basis, both morning and evening to ensure IPA & MSO calls are being routed and answered correctly, by staff.

TYPE	Policy and Procedures
Greeting:	o "Thank you for calling ***Network Name.*** My name is _____. how may I assist you?" o "Network Name" is currently closed until next business day at 8:00 a.m. May I take a message, so that someone can return you call and assist you at the time"? o "Thank you for calling Network Name, have a good day/afternoon/evening"
After Hour Protocol **(Authorizations / Admissions)**	1) Always ask caller to call Primary Care Physician (PCP) first 2) If no PCP information or no response from PCP, ask for IPA, take message including the diagnosis, then give out information of Medical Directors 3) If no response from Medical Directors, page UM On-Call Representative: 4) All calls received from the hospital are logged. A message log is forwarded to IPA/MSO and calls are returned same day message is received.
After Hour Protocol **(Member Services)**	1) If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility. 2) If member needs to speak with PCP, direct member to contact PCP office for after hour service instructions. 3) If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services. 4) If member / Provider call requesting authorization status, PCP change or wants to file a complaint; obtain member information, CIN#, DOB, & Phone number. - Take message and document call. - Member message will be received by the Member services department on the next Business day - Member Service representative will call back member/provider the same day that message is received & document call.

After Hours Representatives are provided Instruction sheets that includes:

On-call HSMSO Representatives	Urgent Care Centers and Phone Number	Hospital Fax Number
Medical Directors	Claim Fax Number	UM Fax Number

Alternative Formats

Alternative Formats (Member Requests)	**1. If member requests for alternative formats such as (Braille, Large Print, Audio Format). The following will occur:** **A. Request is documented in member notes section under Demographics** **B. An "alert" is created in EHCS to notify all departments of member request** **C. The request is coordinated with Interpreters Unlimited** **D. Information is entered in Alternative Format log for tracking purposes.** **Tracking log is located: MSC/Member Services Log\Alternative Format Req. Log**

Review 6.18 SG ; 6.19 SG; 5.20SG

SUBJECT: New Member Welcome & Supplemental Handbook **Policy #**: MS.2

DEPARTMENT: Member Services

Effective Date: February 2005
Last Revision Date: January 2011
Last Review Date: January 2021, January 2023

SCOPE:

This policy applies to all CalOptima lines of business

PURPOSE:

To define the process by which new members are notified of their enrollment status and services offered by their Medical Group.

POLICY:

IPA shall send a welcome letter and a supplemental handbook of information to all new members enrolled with group within seven (7) days of receiving eligibility information from CalOptima.

If the member does not choose a Primary Care Physician (PCP), the IPA will assign a PCP and notify the member via the welcome letter. For members who chose a PCP, the member welcome letter will reiterate their choice of PCP.

The supplemental handbook shall contain PCP specific information as required in CalOptima Policy and Procedure DD.2005 Member Handbook Requirements.

DEFINITIONS

Member – Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHS or the United States Social Security Administration who is enrolled in a health plan contracted with DHS to provide health care services.

Member – Healthy Families: An applicant of eighteen (18) years of age or a child who is eligible for or participates in the Healthy Families Program; referred to as "Subscriber" in the State Healthy Families Program Regulations.

Provider: A physician, nurse, nurse mid-wife, nurse practioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who provides health care items or services.

PROCEDURE

A. IPA shall use the Health Network Template for preparation of the New Member Supplement Handbook.

B. IPA shall submit the New Member Supplement Handbook to CalOptima for approval prior to printing and sending to the member. Any updates made to the Handbook must also be reviewed and approved by CalOptima prior to distribution.

C. IPA shall produce the New Member Supplement Handbook written in the fourth (4^{th}) to fifth (5^{th}) grade reading level in all threshold languages.

D. IPA shall ensure the New Member Supplement Handbook is professionally produced and presented as approved by CalOptima.

E. IPA shall mail the New Member Supplement Handbook to the member's head of household within seven (7) days of receiving notification that such member has enrolled into the health network.

FORMS:

New Member Handbook Supplement
New Member Welcome Letter (PCP chose)
New Member Welcome Letter (PCP not chose)

REFERENCES:

CalOptima Policy and Procedure DD.2005 Member Handbook Requirements.

HEALTH EDUCATION

NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF MID-ORANGE COUNTY

Health Education

Noble and our Health Plans cares about the health of our members. As a benefit in partnering with our Health Plans, we can offer you and your patients several types of education resources.

Forms:

- Health Education Materials Request Form

For additional information on Health Education Resources, please visit our Health Plan Partners' sites:

- CalOptima: https://caloptima.org/en/ForProviders/Resources/HealthEducation.aspx
- Molina: https://www.molinahealthcare.com/providers/common/marketplace/resource/hm/hm.aspx
- Anthem Blue Cross: https://mediproviders.anthem.com/ca/pages/health-education-programs.aspx
- Blue Shield of CA: https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/health-education
- Blue Shield of CA Promise Health Plan: https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/health-education
- WellCare: https://www.wellcare.com/en/California/Health-Wellness
- brand new day: https://bndhmo.com/Members/Health-Education
- Central Health Plan: https://www.centralhealthplan.com/
- Health Net: https://www.healthnet.com/content/healthnet/en_us/health-and-wellness/education.html

HEALTHSMART MANAGEMENT SERVICES ORGANIZATION, INC.

2021 HEALTH EDUCATION PROGRAM

TABLE OF CONTENTS:

I. PURPOSE

II. SCOPE

III. GOALS AND OBJECTIVES

IV. POLICY

V. ROLES AND RESPONSIBILITY

VI. HEALTH EDUCATION DELIVERY MATERIALS AND PROGRAM TOPICS

VII. HEALTH EDUCATION REFERRAL PROCESS

VIII. CONTENT OF HEALTH EDUCATION SERVICES

IX. PROVDIER UPDATES AND EDUCATION

X. HEALTH EDUCATION WORK PLAN

XI. CONFIDENTIALITY

XII. HEALTH PLAN REPORTING

XIII. PROGRAM EFFECTIVENESS

I. PURPOSE

Health Education is the process of providing health information, skill training and support to individuals to enable and empower then to modify their behaviors and improve health status[1]. The Health Education Plan is designed to continually evaluate the effectiveness of health education activities. These activities include member needs assessments, planning, developing, implementing, evaluating and reporting of all health education services.

II. SCOPE

The IPA Panel Providers actively work to improve the health status of its members with chronic conditions by identifying and offering appropriate services and programs through outreach efforts to assist in the management of their conditions. The provider, case manager or health plan may identify these at-risk members. This process will ensure that eligible members are identified for the specific health care programs and a process to contact these members and assist in their enrollment is accomplished. Providers will receive ongoing information and education about the use and referral process for services to meet the needs of their assigned members.

These programs include county, state or federally funded public health programs, carve-out services, hospital or health plan disease management programs or studies.

III. GOALS AND OBJECTIVES

- To provide system of documentation of the health education process from referral to assessment/feedback to ensure member and physician participation in improvement of member's health status.
- To continuously promote avenues of health education through materials distribution, class schedules, calendars, etc., to encourage provider referrals and member participation in health education program.
- To develop, implement and coordinate all health education activities and services, which are geographically desirable and ensure correct education level, cultural beliefs, language and learning style of the member.
- To facilitate the documentation, reporting and follow-up of health education activities in accordance with the Health Education Work Plan.
- To ensure educational services meet members cultural linguistic needs.

IV. POLICY

Health education services will be made available to all members in one or more of the following formats: health education written materials in appropriate language and reading level of the member, one-on-one discussion and training by their primary care provider or other physician; group and support group classes and training session. All health education services are to occur at no cost to the member.

[1] L.A. Care Health Plan: Health Promotion and Education

Health Education referrals may be based from a PCP's assessment of a member's health status, from a review of specific diagnosis and members who may benefit from health education, family request or by a member's direct request for Health Education Services.

V. ROLES AND RESPONSIBILITY

QI Committee –Medical Director

The QI Committee will review annually the Health Education Plan and policies and procedures. The QI Committee will oversee all Health Education activities and designates the Medical Director to be responsible for oversight of the Health Education Work Plan.

Health Education Coordinator

The Health Education Coordinator will be the key contact for daily direction to health education materials/ services and community resources. The Health Education Coordinator will log all health education referrals, activities and material distribution for quarterly reporting to all health plans.

The Health Education Coordinator will work collaboratively with the Medical Director, IPA Case Manager and Primary Care Physician to identify members who may benefit from health education services, ensure follow up and outcome evaluation of health education services.

Primary Care Physician

The Primary Care Physician will play a key role in identification of member's need for health education services and ensure referral for health education topic and service. Referrals are generated through the regular referral process of by contacting the Health Education Coordinator directly. The Primary Care Physician is also responsible for documentation of all one-on-one health education discussions and material distributed.

The Primary Care Physicians are responsible to ensure the Staying Healthy Individual Health Education Behavioral Assessment [SHA] is administered to all new enrollees within 120 days of their enrollment for members 18 months and over; 60 days for members under 18 months.

Case Management Nurse

The Case Management Nurse will ensure member participation in health education referral services; obtain a copy of curriculum and assessment by instructor and copy of the member satisfaction with the quality of the health education program attended.

VI. HEALTH EDUCATION DELIVERY MATERIALS AND PROGRAM TOPICS

Health education will be delivered to members either one-on-one, or in group or support group/classroom formats. A Primary Care Physician or Specialty Referral Physician, health educator, nurse, medical assistant or other staff that are trained to instruct members on the specific topic may provide health education in these formats. A one-on-one counseling session may occur separate from the member's regular medical visit. Support group sessions usually are one to two hours in duration and provide emotional and social support for members. Classroom instruction is provided at contracted hospitals. Individual hospital calendars are available for providers.

Health education materials may come in the form of brochures, videos, audiotapes and/or newsletters. The brochures, videos and audio tapes will be obtained from the IPA's contracted health plans and be accompanied with a Materials Review Form to ensure that reading level assessment, language assessment, cultural competency and medical accuracy has already been established. Any materials that have not been received from a health plan or plan partner or state agency will not be distributed to members.
It is mandatory that the IPA ensure access to materials or services for the following topics:

- Anticipatory Guidance
- Asthma
- Child & Adult Obesity/Weight Management
- Complementary and Alternative Medicine
- Dental Health
- Diabetes
- Exercise
- Family Planning/Pregnancy
- HIV/STD
- Hypertension
- Immunizations
- Injury Prevention
- Lead Poisoning*
- Nutrition
- Parenting
- Perinatal/Breast Feeding Promotion
- Substance Abuse
- Stress/Depression
- Tobacco Prevention/Cessation
- Tuberculosis
- Unplanned Pregnancy
- Well-child

VII. HEALTH EDUCATION REFERRAL PROCESS

The Primary Care Physicians will utilize the regular referral process for referring members to other specialty physicians for one-on-one health education. The physicians are encouraged to contact the Health Education Coordinator by telephone or fax if they are unable to identify a source for the specific topic of member's need. All health education referrals will meet timely processing and direction to health education referral source.

Monitoring of health education referrals will ensure a closed loop process, which includes:

- Log of health education referrals.
- Follow up activities to ensure member participation.
- Documentation of member no show and follow up contact to schedule for next available appointment/class.
- Copy of attendance sheet, program outline and assessment evaluations.
- Documentation of report back to Primary Care Physician.

VIII. CONTENT OF HEALTH EDUCATION SERVICES

All health education materials and services will take into account member age, education level, cultural beliefs, language and learning style. Materials will be at a 5th grade or less reading level. Members will be offered interpreting services where needed.

All health education services will provide the following:

- General overview of the disease and condition, including: definition, cause, signs and symptoms, modes of transmission, effect, impact of behavior and prevention guidelines.
- Methods of prevention.
- Skills needed to achieve desired outcome/management.
- Identification of barriers to achieving desired outcome.
- Referral to community resources for additional support as needed.
- Plan of action to achieve goal.

All health education classes must have a written outline and curriculum with measurable goals and objectives, content outline, instructional methods including any use of videos and materials distributed and a copy of the evaluation tool used. Class instructors will maintain a sign in sheet of participants that lists location and time class was called to order and adjourned. Class instructors will complete class by having participants do an assessment of their satisfaction with the content presented, quality of the instructor and if members expectations and needs were addressed. Copies of the completed participant evaluations and class curriculum must be available for review.

IX. PROVDIER UPDATES AND EDUCATION

The Health Education Coordinator will ensure distribution of any provider education and any DHS requirements to all primary care physicians and where appropriate, specialty providers. This includes, but is not limited to, notices regarding Health Plan Educational seminars, Preventive Health Guidelines, Information on program updates, etc. This information will be distributed as described in the Dissemination of Information policy.

X. HEALTH EDUCATION WORK PLAN

The IPAs will complete and submit a Health Education Work Plan to all participating health plans by January 31st of each year. The work plan will document the goals and objectives to be accomplished within the calendar year. The work plan will contain a list of activities planned with goal and objective, timeline for completion of activity, person responsible, evaluation and corrective measure put in place. A status report of the work plan activities will be submitted to the health plans on a quarterly basis.

X1. CONFIDENTIALITY

All documentation, records and proceedings shall be maintained in a confidential manner and in accordance with Section 1157 of the California Civil Evidence Code.

XII. HEALTH PLAN REPORTING

Quarterly Health Education Utilization Reports will be submitted to the health plans with the following information:

- Member information
- Health topic, Title of Program or Material Distributed
- Name of Location and Program Format
- Date of service/Distribution
- Language of Instructor
- Attendance

All referrals for health education services will be submitted to the health plans on a monthly basis as per the regular UM Reporting process. The monthly referral report activity will also be added to the quarterly Health Education Utilization Report.

XIII. PROGRAM EFFECTIVENESS

An annual summary and evaluation report on the overall effectiveness of the Health Education Plan and Work Plan will be compiled and presented to the Quality Management Committee. The QM Committee will assess barriers and areas for improvement and provider recommendations for revisions.

HEALTHSMART MSO, INC.
HEALTH EDUCATION MATERIALS REQUEST FORM

Provider: _____ **Date:**_____

IPA: _____

Please check off the items you are requesting and fax your Request Forms Attn: Health Education Coordinator **Fax No: (714) 947-8611**

	Staying Healthy
	Anticipatory Guidance
	Asthma
	Child & Adult Obesity/Weight Management
	Dental Health
	Diabetes
	Domestic Violence
	Exercise
	Family Planning/Pregnancy
	HIV/STD
	Hypertension
	Immunizations
	Injury Prevention
	Lead Poisoning
	Nutrition
	Perinatal/Breast Feeding Promotion
	Substance Abuse
	Stress/Depression
	Tobacco Prevention/Cessation
	Tuberculosis
	Well Child
	Other:
	Other:

Please check the language in which the materials are needed in:

_____ English
_____ Russian
_____ Cambodian/Khmer
_____ Mandarin
_____ Farsi
_____ Vietnamese
_____ Armenian
_____ Korean
_____ Cantonese/Chinese
_____ Tagalog
_____ Spanish

Other: _____

COMPLIANCE

NOBLE COMMUNITY MEDICAL ASSOCIATES OF MID-ORANGE COUNTY

Compliance and Compliance Training

Federal and state regulations require our Health Plans to ensure delegated entities like Noble to monitor monthly and annually compliance requirements to our contracted first-tier downstream and related entities (FDRs), as well as FDRs employees who are involved in administration or delivery of Medicare and Medicaid Benefits.

Below is the list of required trainings, but not limited to and may subject to change:

- Medicare Part C and D General Compliance Training (Annual)
- Medicare Part C and D Fraud, Waste, and Abuse (Annual)
- HIPPA Training (Annual)
- Participation in Federal Programs Verification Requirement (Monthly)
- Compliance Program Code of Conduct (Annual)
- Access & Availability (Annual)

Please visit our site for additional information on Compliance Trainings available:

- http://healthsmartmso.com/

Enclosed: Training Attestations

Reporting Fraud, Waste and Abuse

Federal and state regulations require Health Plans and delegated entities to work with its providers to identify and report potential cases of health care fraud, waste or abuse to law enforcement agencies.

Enclosed: CalOptima Suspected Fraud or Abuse Referral Form

To obtain the Medicare Fraud & Abuse: Prevent, Detect, Report booklet, please visit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

SUBJECT: Fraud and Abuse Detection and Reporting **Policy #**: AD.3
DEPARTMENT: Administration

Effective Date: February 2005
Last Revision Date: October 21, 2016
Last Review: January 2026

SCOPE:

This policy applies to all lines of business. [Commercial, Medi-Cal & Medicare/Medicare Advantage/Cal Medi-Connect and Capitated Financial Alignment Demonstration (CFAD)]

PURPOSE:

To establish a process for detecting suspected Fraud or Abuse of the Medi-Cal and/or Medicare/Medicare Advantage Programs by a Member, Provider, Billing Intermediary, or Health Network in accordance with federal and state regulations.

POLICY:

IPA maintains a **zero-tolerance** policy towards Fraud and Abuse.

IPA shall establish a process for detecting and reporting suspected Fraud or Abuse in accordance with this policy.

IPA and its contracted providers shall comply with statutory, regulatory and other requirements; sub regulatory guidance; and its contractual commitments related to the delivery of care which includes but is not limited to federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducement to beneficiaries, Health Insurance Portability and Accountability Act and other applicable statutes.

Employees and providers shall attend training and information sessions regarding Fraud and Abuse offered by health plans.

DEFINITIONS:

Abuse: An IPA or Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in unnecessary cost to the Medi-Cal, Healthy Families and/or Medicare/Medicare Advantage program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal, Healthy Families and/or Medicare/Medicare Advantage program.

Authorized Representative: A person granted legal authority to make health care decisions for an adult or emancipated minor, a parent or guardian of a minor, any other person acting *in loco parentis*, or a person with legal authority to act on behalf of a decedent or a decedent's estate.

Benefits Identification Card (BIC): A plastic card issued by the Department of Health Services (DHS) to each Medi-Cal beneficiary that identifies the beneficiary's Medi-Cal identification number, name, date of birth, gender, and the date the card is issued.

Billing Intermediary: Any person, partnership, group, association, corporation, institution, entity, or sole proprietorship that bills a health plan or IPA on behalf of a Provider pursuant to a contractual relationship with the Provider. A person directly employed by a Provider or a person with a family relationship to the Provider who prepares and submits claims for the Provider is not considered a Billing Intermediary.

Contract: The written instrument between an IPA and physicians, hospitals, health maintenance organizations (HMOs), or other entities.

Covered Services: Those services set forth in IPA and health plan contracts.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, as defined in Title 42, Code of Federal Regulations Section 455.2. It includes any act that constitutes Fraud under applicable federal or state law.

Immediate Family: A spouse, child, stepchild, parent, sibling, grandparent, father-in-law, mother-in-law, daughter-in-law, or son-in-law.

Kickback: A rebate or anything of value or advantage, present or prospective, or any promise or undertaking to give any such rebate or thing of value or advantage, with a corrupt intent to unlawfully influence the person to whom it is given in actions undertaken by that person in his or her public, professional, or official capacity, as defined in the California Welfare and Institutions Code Section 14107.2.

Member – Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHS or the United States Social Security Administration who is enrolled in a health plan contracted with DHS to provide health care services.

Member – Healthy Families: An applicant of eighteen (18) years of age or a child who is eligible for or participates in the Healthy Families Program; referred to as "Subscriber" in the State Healthy Families Program Regulations.

Member – Medicare (Parts A&B): An applicant of sixty-five (65) years or older **or** a person under age sixty-five (65) who has a certain disability or end-stage renal disease.

Member –Medicare Advantage (Part C): Same as Member – Medicare (Parts A&B). Medicare Advantage is a plan offered by a private organization as an alternative to Parts A&B only.

Prescription: Oral, written, or electronic transmission order that meets the requirements of the California Business and Professions Code, Chapter 9, Division 2, Article 2 "Definitions", Section 4040 "Prescription: Content Requirements", except any Prescription written by a veterinarian.

Provider: A physician, pharmacist, nurse, nurse midwife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health care service plan, Health Network, or other person or entity who furnishes Covered Services.

Reports: Responses to health plan requirements or requests for information including, but not limited to, written documents or data files in support of health plan policies.

Significant Beneficial Interest: Any financial interest that is equal to or greater than $25,000 of ownership interest, five percent (5%) of the whole ownership, or any other contractual or compensatory arrangement with vendors or contractors or Immediate Family of vendors or contractors. Interests held by a Provider and the Provider's Immediate Family shall be combined and included as a single interest.

PROCEDURE:

A. IPA may detect Fraud or Abuse by a Member in circumstances that include, but are not limited to, the following:

1. Using another individual's identity, Benefits Identification Card (BIC), Health Plan identification card, Medi-Cal number, or other documentation of Medi-Cal, Healthy Families and/or Medicare/Medicare Advantage program eligibility to obtain Covered Services, unless such person is an Authorized Representative who is presenting such document or information on behalf of a Member to obtain Covered Services for that Member.

2. Selling, loaning, or giving a Member's identity, Benefits Identification Card (BIC), Health Plan identification card, Medi-Cal number, or other documentation of Medi-Cal, Healthy Families and/or Medicare/Medicare Advantage program eligibility to another individual to obtain Covered Services, unless such person is an Authorized Representative who is obtaining services on behalf of a Member.

3. Making an unsubstantiated declaration of eligibility.

4. Using a Covered Service for purposes other than the purposes for which it was prescribed or provided, including use of such Covered Service by an individual other than the Member for whom the Covered Service was prescribed or provided.

5. Failing to report other health coverage; and

6. Soliciting or receiving a Kickback, bribe, rebate, or other financial incentive as an inducement to receive or not receive Covered Services.

B. IPA may detect Fraud or Abuse by a Provider, Billing Intermediary, or Health Plan circumstances that include, but are not limited to, the following:

1. Unsubstantiated declaration of eligibility to participate in Medicare, Medi-Cal or Healthy Families program as a Provider, Billing Intermediary, or Health Plan.

2. Submission of a claim or a request for payment for:

a. Covered Services that are substantially and demonstrably in excess of an individual's usual charges for such Covered Services.

b. Covered Services that were not provided to the Member for whom such Covered Services were claimed.

c. Covered Services substantially in excess of the quantity that is medically necessary for the Member.

d. Covered Services using a billing code that will result in greater payment than the billing code that reflects the Covered Services actually provided.

e. Covered Services that were already included in the capitation rate; and

f. Covered Services billed to both CalOptima and another third-party payer without making full disclosure of material facts or notification of other insurance payments.

3. Charging a Member in excess of allowable co-payments or deductibles for Covered Services.

4. Billing a Member for Covered Services without obtaining written consent to bill for such Covered Services.

5. Soliciting, offering, receiving, or paying a Kickback, bribe, or rebate as an inducement to refer or fail to refer a Member.

6. Failing to disclose any Significant Beneficial Interest in any other Provider to which the Provider may refer a Member for the provision of Covered Services.

7. Billing Intermediary failure to register with DHS.

8. False certification of medical necessity.

9. Attributing a diagnosis code to a Member that does not accurately reflect the Member's medical condition for the purposes of obtaining higher reimbursement.

10. Providing a false or inaccurate credentialing information; and

11. Submitting data files or Reports that contain:

    a. Unsubstantiated data.

    b. Data that is inconsistent with underlying clinical, encounter, or payment records; or

    c. Data that has been altered in a manner or for a purpose that is inconsistent with IPA policies, Contract, or applicable regulations and statutes.

C. Any employee who detects suspected Fraud or Abuse shall complete a Suspected Fraud or Abuse Referral Form and transmit it to Administration.

D. IPA and any other entity with a contractual obligation to report suspected Fraud or Abuse shall notify the health plan of suspected Fraud or Abuse in accordance with the terms and conditions of its Contract and this policy.

E. Methods shall be provided for employees, IPA, Providers, and Members to anonymously report suspected Fraud or Abuse to Administration.

1. Employees, IPAs, Providers, and Members may call the Department of Health Services (DHS) Medi-Cal Fraud Line at (800) 822-6222; or

2. Employees, IPAs, Providers, and Members may mail information regarding suspected Fraud or Abuse to the HSMSO PO Box address at:

P.O. Box 6300
Cypress, CA 90630-0063

3. Employees, IPAs, Providers and Members may also verbally report directly to the Privacy Officer by calling (714) 947-8600 or the Health Plans Hotline.

F. IPA shall notify health plans immediately upon notice of an activity. [CalOptima notification will occur within 10 days of when the group became aware of or is on notice of an activity]. Call will be made to the Health Plans Fraud Hotline and/or written report will be sent to the Health Plan's designated Medicare Compliance Officer.

When applicable, IPA will report suspected Fraud, Waste and Abuse directly to Centers for Medicare and Medicaid Services (CMS) or the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) for further investigation. Reports to NBI MEDIC will include issues related to Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Coverage).

G. IPA will identify, investigate, and take corrective action when indicated.

H. IPA will report the results of investigation to health plan within ten (10) days.

I. Employees and providers shall attend training and information sessions regarding Fraud and Abuse offered by health plans.

FORMS

Suspected Fraud or Abuse Referral Form

REFERENCE

Title 42, Code of Federal Regulations, Section 455.2
California Business and Professions Code, Section 4040
California Welfare and Institutions Code, Sections 14026 and 14107.2

SUBJECT: Correspondence/Dissemination of Information **Policy #:** AD.4
DEPARTMENT: Administration

Effective Date: December 12, 1997
Last Revision Date: August 2008
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To describe the process used to send correspondence to providers to ensure that they are kept up to date with health plan(s) and DHS policy guidelines, and to provide a process of dissemination of information that is trackable.

POLICY:

Correspondence to providers can be disseminated via mail, facsimile, or the case of emergency via telephone.

A monthly correspondence log is kept tracking all information that was sent out. The log will include the information regarding to whom it was sent, topic or information sent, the date it was sent and the method used to disseminate it.

It is the provider's responsibility to review and implement information sent in a timely manner and maintain all updates in their Provider Manual under the related topic.

A log of all information sent to providers will be made available for health plans to review for verification of dissemination of information.

DEFINITION:

Correspondence: Refers to health plan, provider, IPA policy and regulatory updates, health plan seminars and meetings, health education material and any memos to the providers.

Urgent Correspondence: Any correspondence that effects patient care standards in a manner that requires a provider to be notified of these within 72 hours of receipt by Management Company, and meeting notifications, memos or other information requiring provider action in less than 30 days.

PROCEDURE:

1. When correspondence is identified for need of distribution, the Provider Service Department will log the information identifying who the information needs to be sent to.

2. The information will then be evaluated for urgency of distribution. If immediate action is necessary, the providers may be contacted by telephone with a fax follow-up.

3. If the information does not require immediate attention, the Provider Services Department may elect to send the information to the providers through the monthly mailing process.

4. All activity is logged using the Monthly Correspondence Log (sample attached). These logs may be reviewed by the health plans for verification of dissemination of information.

FORMS

Monthly Correspondence Log

REFERENCES

None

Downstream Regulatory Amendment for Contracted Providers

Business Associate Protected Health Information Disclosure Agreement

This Business Associate Protected Health Information Disclosure Agreement ("Agreement") is entered into by and between **Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid Orange County** ("IPA"), and the BA ("Business Associate"), on this **____day of _____.**

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to IPA, and Business Associate receives, has access to or creates Protected Health Information in order to provide those services ("Services Agreement(s)"):

WHEREAS, as a Covered Entity, IPA is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated there under, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Regulations") and the Security Standards for Electronic Protected Health Information ("Security Regulations") at 45 Code of Federal Regulations Parts 160 and 164 (together, the "Privacy and Security Regulations");

WHEREAS, as a Business Associate, VENDOR is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated there under, as required by the HITECT Act, pursuant to Title XIII3 of the American Recovery and Reinvestment Act of 2009;

WHEREAS, the Privacy and Security Regulations require IPA to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place:

WHEREAS, the IPA's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to protect Protected Health Information and have required that IPA incorporate such requirements in its subcontracts with subcontractors that require access to the regulator(s)' Protected Health Information;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 "Electronic Media" means:

(1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable /transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

1.3 "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

1.4 "HHS" means the federal Department of Health and Human Services.

1.5 "HITECH Act" means the Health Information Technology for Economic and Clinical Health (HITECH) Act, codified at 42 U.S.C. §§ 17921–17954.

1.6 "Information System" means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.7 "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.8 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of IPA. Protected Health Information includes information that (i) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an Individual; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of IPA, or is created by Business Associate, or is made accessible to Business Associate by IPA. "Protected Health Information" includes Electronic Protected Health Information.

1.9 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

1.10 "Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or any administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.11 "Services" has the same meaning as in the Services Agreement(s).

1.12 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

1.13 "Unsecured Protected Health Information" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary of HHS.

1.14 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Regulations.

OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 HITECH Compliance. Business Associate will comply with the requirements of Title XIII, Subtitle D of the HITECH Act, which are applicable to business associates, and will comply with all regulations issued by HHS to implement these referenced statutes, as of the date by which business associates are required to comply with such referenced statutes and HHS regulations. Business Associate is also required to comply with the specific security administrative, physical and technical safeguards identified on Attachment A.

2.2 Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services , and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 3.3 and 4.1 of this Agreement;

(b) shall Disclose Protected Health Information to IPA upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is required by law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2.2 Adequate Safeguards for Protected Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

Specifically as to Electronic Protected Health Information, Business Associate warrants that it shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information.

2.3 Notification of Breach. During the term of this Agreement:

(a) Discovery of Suspected or Actual Breach, Security Incident, Intrusion or Unauthorized Use or Disclosure of PHI or Loss of Confidential Data. Business Associate agrees to notify IPA immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form, or any suspected Security Incident, intrusion or unauthorized Use or Disclosure of PHI in violation of this Agreement, or potential or actual loss of confidential data related to the Services Agreement(s). Notification shall be provided to the IPA's Privacy Officer (IPA's Director of Compliance), telephone number (714) 947-8600. Business Associate shall take:

(i) Prompt corrective action to mitigate any risks or damages involved with the breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data and to protect the operating environment. Notwithstanding the foregoing, all corrective actions are subject to the approval of IPA and the IPA's regulator(s).

(ii) Any action pertaining to such breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data required by applicable Federal and State laws and regulations.

(iii) Any additional corrective actions required by IPA or IPA's regulator(s).

(b) Investigation of Suspected or Actual Breach, Security Incident, Intrusion or Unauthorized Use or Disclosure of PHI or Loss of Confidential Data. Business Associate agrees to immediately investigate such Security Incident, breach, or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data. Within three (3) working days of the discovery, Business Associate shall notify the IPA Privacy Officer of matters described below:

(i) The nature of the data elements involved and the extent of the data involved in the breach,

(ii) A description of the unauthorized persons known or reasonably believed to have improperly Used or Disclosed PHI or confidential data,

(iii) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,

(iv) A description of the probable causes of the improper Use or Disclosure;

(v) Whether the PHI or confidential data that is the subject of the Security Incident, breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured Protected Health Information;

(vi) Whether a law enforcement official has requested a delay in notification of individuals of the Security Incident, breach, or unauthorized Use or Disclosure of PHI or confidential data because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

(vii) Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), Civil Code sections 1798.29 or 1798.82 or any other federal or state laws requiring individual notifications of breaches are triggered.

(c) Written Report. Business Associate shall provide a comprehensive written report to IPA no later than ten (10) working days after discovery of the Security Incident, breach, or other unauthorized Use or Disclosure of PHI or confidential data, providing a comprehensive discussion of the above matters identified in section 2.3(b) above and the following matters:

(i) The potential impacts of the incident, e.g. potential misuse of date, identity theft, etc.;

(ii) The steps taken in mitigation to reduce the harmful effects of the breach, as required by Section 2.4; and

(iii) A corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future. Notwithstanding the foregoing, all corrective actions are subject to the approval of IPA and the IPA's regulator(s).

2.4 Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5 Notification of Breach to Individuals. Business Associate shall comply with federal and state laws requiring notice to individuals of breaches of PHI or confidential data including, without limitation, Section 13402 of the HITECH Act, codified at 42 U.S.C. § 17932. Business Associate shall comply with all regulations issued by HHS to implement Section 13402, as of the date by which business associates are required to comply with such referenced statutes and HHS regulations. All such notifications to affected individuals shall be coordinated with the IPA and IPA shall approve the time, manner, content and method for notice to individuals including, without limitation, requiring Business Associate to directly send and pay for such notices at the IPA's discretion. Business Associate will immediately indemnify and pay IPA for (i) any and all fees and expenses the IPA incurs in investigating, responding to, and/or mitigating a breach of PHI or confidential data caused by Business Associate or its subcontractors or agents; (ii) any damages, attorneys fees, costs, liabilities or other sums actually incurred by IPA due to a claim, lawsuit, or demand by a third party arising out of a breach of PHI or confidential data caused by Business Associate or its subcontractors or agents; and/or (iii) for fines, assessments and/or penalties assessed or imposed against IPA by any government agency/regulator based on a breach of PHI or confidential data caused by Business Associate or its subcontractors or agents. Such fees and expenses may include, without limitation, attorneys fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges.

2.6 Employee Training and Discipline. Business Associate agrees to train and use reasonable measures to ensure compliance with the requirements of this Agreement by employees, volunteers and, if permitted, subcontractors who assist in the performance of functions or activities under this Agreement and Use or Disclose PHI. Business Associate agrees to discipline such employees, volunteers and subcontractors who intentionally violate any provisions of this Agreement, including by termination of employment or subcontract.

2.7. Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of HHS for purposes of determining the IPA's

compliance with the Privacy and Security Regulations. . Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the IPA and the Secretary of HHS for purposes of determining Business Associate's compliance with the applicable Privacy and Security Regulations. Business Associate shall immediately notify IPA of any requests made by the Secretary of HHS and provide IPA with copies of any documents produced in response to such request.

2.8 Access to Protected Health Information. Business Associate shall, to the extent IPA determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by IPA available to the Individual(s) identified by IPA as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within thirty (30) calendar days after receipt of request from the IPA. Business Associate shall also provide copies of that Protected Health Information within thirty (30) calendar days after receipt of request from the IPA.

2.9 Amendment of Protected Health Information. Business Associate shall, to the extent IPA determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by the IPA. Business Associate shall make such amendment within thirty (30) calendar days after receipt of request from the IPA in order for the IPA to meet the requirements under 45 C.F.R. § 164.526.

2.10 Accounting of Disclosures. Upon the IPA's request, Business Associate shall provide to the IPA an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or subcontractors.

Any accounting provided by Business Associate under this Section 2.8 shall include:

(a) the date of the Disclosure;

(b) the name, and address if known, of the entity or person who received the Protected Health Information;

(c) a brief description of the Protected Health Information disclosed; and

(d) a brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section 2.8, Business Associate shall document the information specified in (a) through (d), above, and shall securely maintain the information for six (6) years from the date of the Disclosure (but beginning no earlier than April 14, 2003). Business Associate shall not, however, be required to maintain such information for disclosures of Protected Health Information:

(a) to carry out treatment, payment, and health care operations on behalf of the IPA, or that are incident to such disclosures;

(b) to individuals of protected health information about them; or

(c) pursuant to a written authorization given by or on behalf of the individual.

Business Associate shall provide to the IPA, within thirty (30) calendar days after receipt of request from the IPA, information collected in accordance with this Section 2.8 to permit the IPA to respond to a

request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

2.11 Audits, Inspection and Enforcement. From time to time, the IPA may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of any provision of this Agreement and shall certify the same to the IPA in writing. The fact that the IPA inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor do the following constitute acceptance of the IPA's:

(a) Failure to detect or

(b) Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of the IPA's enforcement rights under this Agreement.

TERM AND TERMINATION

3.1 Term. This Agreement shall remain in effect as long as any Services Agreement is in effect. Business Associate's obligations under Sections 2.1, 2.2, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10 and 3.3 shall survive the termination or expiration of this Agreement.

3.2 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon the IPA's knowledge of a material breach by Business Associate, the IPA shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by the IPA; or

(b) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

If neither termination nor cure is feasible, the IPA shall report the violation to the Secretary of HHS.

3.3 Disposition of Protected Health Information upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all Protected Health Information received from the IPA, or created or received by Business Associate on behalf of the IPA in accordance with data destruction methods specified in Attachment __ to this Agreement. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to the IPA notification of the conditions that make it infeasible. Subject to the approval of the IPA's regulator(s) if necessary, if return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such

Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

MISCELLANEOUS

4.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of the IPA, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

4.2 Regulatory References. A reference in this Agreement to a section in the Privacy and Security Regulations means the section as in effect or as amended.

4.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the IPA to comply with the Privacy and Security Regulations.

4.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the IPA to comply with the requirements of the Privacy and Security Regulations.

Attachment A

Noble Community Associates, Inc. of Mid Orange County

Business Associate Data Security Requirements
Subcontractors with Access to DHCS Data and PHI

DEFINITIONS

A. "DHCS Data" means for purposes of this Attachment A, all information provided by DHCS to the IPA, which is accessed by Business Associate under the Services Agreement.

B. "DHCS PHI" means for purposes of this Attachment A, Protected Health Information and a subset of DHCS Data.

C. "Approved Technical Encryption Solution" means an encryption solution approved by the IPA's regulator(s).

I. GENERAL SECURITY CONTROLS

1.1 Confidentiality Statement. All persons that will be working with DHCS PHI must sign an annual confidentiality statement prior to access to DHCS PHI. Business Associate shall retain each person's written confidentiality statement for the IPA's inspection for a period of three (3) years following contract termination.

1.2 Background check. Before a member of the Business Associate's workforce may access DHCS PHI, Business Associate must conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data. The Business Associate shall retain each workforce member's background check documentation for the IPA's inspection for a period of three (3) years following contract termination.

1.3 Workstation/Laptop encryption. All workstations and laptops that process and/or store Protected Health Information must be encrypted with an Approved Technical Encryption Solution.

1.4 Minimum Necessary. Only the minimum necessary amount of DHCS PHI may be downloaded to a laptop or hard drive when absolutely necessary for current business purposes.

1.5 Removable media devices. All electronic files that contain DHCS PHI must be encrypted when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, etc.) with an Approved Technical Encryption Solution

1.6 Email security. All emails that include DHCS PHI must be sent in an encrypted method using an Approved Technical Encryption Solution.

1.7 Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.

1.8 Patch Management. All workstations, laptops and other systems that process and/or store DHCS PHI must have security patches applied and up-to-date.

1.9 User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI. Passwords are not to be shared, must be at least eight characters, be a non-dictionary word, stored in readable format on the computer, changed every 60 days, and changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

1.10 Data Destruction. All PHI must be wiped from systems when the data is no longer necessary. The wipe method must conform to Department of Defense standards for data destruction (known as DoD 5220.22-M) or other solution approved in advance by the IPA's regulator(s). All paper containing DHCS data must be shredded. Once data has been destroyed, the IPA must be notified.

1.11 Remote Access. Any remote access to DHCS PHI must be executed over an Approved Technical Encryption Solution. All remote access must be limited to minimum necessary and least privilege principles.

II. SYSTEM SECURITY CONTROLS

2.1 System Timeout. The system must provide an automatic timeout after no more than 20 minutes of inactivity.

2.2 Warning Banners. All systems containing DHCS PHI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. Users must be directed to log off the system if they do not agree with these requirements.

2.3 System Logging. The system must log success and failures of user authentication at all layers. The system must log all system administrator/developer access and changes if the system is processing and/or storing DHCS PHI. The system must log all user transactions at the database layer if processing and/or storing DHCS PHI.

2.4 Access Controls. The system must use role based access controls for all user authentications, enforcing the principle of least privilege.

2.5 Transmission encryption. All data transmissions must be encrypted end-to-end using an Approved Technical Encryption Solution when transmitting PHI such as solutions using 128bit SSL, FTPS or SFTP.

2.6 Host Based Intrusion Detection. All systems that are accessible via the Internet or store DHCS PHI must actively use a comprehensive third-party real-time host based intrusion detection and prevention solution.

III. AUDIT CONTROLS

3.1 System Security Review. All systems processing and/or storing DHCS PHI must have at least an annual system security review. Reviews must include administrative and technical vulnerability scanning tools.

3.2 Log Reviews. All systems processing and/or storing DHCS PHI must have a routine procedure in place to review system logs for unauthorized access.

3.3 Change Control. All systems processing and/or storing DHCS PHI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. BUSINESS CONTINUITY / DISASTER RECOVERY CONTROLS

4.1 Emergency Mode Operation Plan. Business Associate must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic PHI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under the Services Agreement(s) for more than 24 hours.

4.2 Data Backup Plan. Business Associate must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and the amount of time to restore DHCS PHI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of the IPA's data.

V. PAPER DOCUMENT CONTROLS

5.1 Supervision of Data. DHCS PHI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

5.2 Escorting Visitors. Visitors to areas where DHCS PHI is contained shall be escorted and DHCS PHI shall be kept out of sight while visitors are in the area.

5.3 Confidential Destruction. DHCS PHI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

5.4 Removal of Data. If the IPA provides Business Associate with access to DHCS PHI to perform services off-site (i.e. not at the IPA's business premises), Business Associate shall not remove DHCS PHI to any overseas or offshore location. In the event that Business Associate is permitted to deliver DHCS PHI to any party as part of its obligations under the Services Agreement(s), then Business Associate shall comply with all safeguard requirements related to the transmission and/or delivery of DHCS PHI set forth in this Attachment.

5.5 Faxing. Faxes containing DHCS PHI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending.

5.6 Mailing. DHCS PHI shall only be mailed using secure methods. Large volume mailings of PHI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted with an Approved Technical Encryption Solution.

***PLEASE ATTACHED TO YOUR NOBLE COMMUNITY MEDICAL ASSOCIATES, INC. OF ORANGE COUNTY AGREEMENT**

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid Orange County
C/O: HealthSmart Management Services Organization, Inc.
Mailing: Post Office Box 6300, Cypress, CA 90630-6300
Phone: (714) 947-8600; Fax: (714) 947-8708

April 15, 2022

Dear Valued Contracted Providers:

As you are aware, the Centers for Medicare & Medicaid Services (CMS) and CalOptima requires Noble Mid-Orange County to provide and have all contracted providers to complete the Fraud, Waste and Abuse (FWA), the Health Insurance Portability and Accountability Act (HIPAA), and general compliance trainings. We're required by the health plan to ensure that all participating providers and their staff members complete the compliance training and provide a signed attestation to substantiate that this CMS requirement has been met.

To complete the training, please log onto **our website at www.healthsmartmso.com**, and click on the below listed presentations, under the Fraud, Waste, and Abuse & General Compliance Training section:

1. HIPAA Training
2. Combating Medicare Parts C and D Fraud, Waste, and Abuse
3. ICE General Compliance Training
4. Compliance Program Code of Conduct
5. Access and Availability Standards

The attestation is enclosed for your use and is also posted under the Fraud, Waste, and Abuse & General Compliance Training section of www.healthsmartmso.com.

Please complete and return the Mandatory Annual Trainings Attestation by
Friday, May 29, 2022.

The signed attestation form may be faxed to (714) 947-8708 or email to Provider Services at providerservice@healthsmartmso.com

We appreciate your cooperation. Should you have any questions pertaining to this matter, please feel free to contact HealthSmart Provider Services at (714) 947-8600 or via email at providerservice@healthsmartmso.com.

Thank you for your assistance.

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid Orange County

Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid Orange County
C/O: HealthSmart Management Services Organization, Inc.

Mailing: Post Office Box 6300, Cypress, CA 90630-6300
Phone: (714) 947-8600; Fax: (714) 947-8708

HIPAA, General Compliance, and Fraud, Waste, and Abuse Training

The mandatory annual trainings **must be completed within ten (10) days of receipt.** Please attest below and fax back or by email.

To complete the training, please log onto **our website at www.healthsmartmso.com.** The trainings are listed under **Fraud, Waste, and Abuse & General Compliance Training**

Date of Completed Training: _____

Provider Name (Print Full Name): _____

Provider NPI: _____

Provider Signature: _____

Email Address: _____

Office Manager (Print Full Name) _____

By signing this attestation, your office has acknowledged that all the appropriate staff have taken the necessary trainings listed below.

1. HIPAA Training
2. Combating Medicare Parts C and D Fraud, Waste, and Abuse
3. ICE General Compliance Training
4. Compliance Program Code of Conduct
5. Access and Availability Standards

**As a reminder, all staff who have contact with or support CalOptima and Noble Community Medical Associates, Inc. of Mid Orange County members must complete the mandatory training.*

Please Fax Attestation to (714) 947-8708 or via email to Provider Services at providerservice@healthsmartmso.com.

We thank you for your continued support and providing quality care to the members.

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid Orange County

Orange County Physicians IPA Medical Group, Inc.
dba Noble Community Medical Associates, Inc. of Mid-Orange County
C/O HealthSmart Management Services Organization, Inc.

Mailing Address: P.O. Box 6300, Cypress, CA 90630-0063
Live Operator: (714) 947- 8600
Fax: (714) 947-8708

Participation in Federal Programs Verification Requirement

Provider Requirements for New and Existing Provider Staff for Monthly Verifications and Attestation Submissions:

Provider office(s) are required to conduct and review the Medi-Cal Suspended & Ineligible, Office of the Inspector General (OIG), and System for Award Management (SAM) list of Excluded Individuals and Entities (LEIE list) prior to the hiring, employing, or contracting of any new, temporary, volunteer employee(s), and/or consultants, and **monthly thereafter**, to ensure that none of these persons or entities are excluded or become excluded from participation in federal programs.

- ✓ Provider office(s) must provide evidence of new provider office staff are pre-screened prior to hire and monthly thereafter
- ✓ Providers are required to conduct monthly database searches for all provider office staff
- ✓ A signed monthly attestation (attached) is required to confirm that the search has been conducted and reviewed

The monthly attestation must be submitted to your contracted Independent Physician Associations (IPA) via fax (714) 947-8708 by the end of each month. Below are the required links for each of the verification websites

Medi-Cal Suspended & Ineligible List

https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

HHS OIG (Inspector General's Office in the Federal Government) dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs.

https://exclusions.oig.hhs.gov/

SAM (System for Award Management) registration helps to streamline the acquisition of grant, loans, contracts and intergovernmental transactions. According to the General Services Administration (GSA), the federal government plans on integrating ten (10) different federal procurement systems and the Catalog of Federal Domestic Assistance into a single, streamlined system that uses the Integrated Award Environment (IAE).

https://sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf

Participation in Federal Programs Verification Requirement

OIG/SAM/Medi-Cal Exclusions Screening Attestation

As a first-tier, downstream or related entity that participates in one or more governmental funded health care program, the organization identified in the signature block below attests to the following.

- That we review the Office of the Inspector General (OIG) and General Services Administration System for Award Management (SAM) exclusion lists and Medi-Cal Suspended and Ineligible Provider List upon initial hire/contract and monthly thereafter to ensure that any new employee, manager or downstream entity is not included in any such list.

- If an employee, manager or downstream entity is on such lists, the organization will terminate such person or entity and notify PMD or PMG of the person or entity's identity.

- Your organization will retain and furnish confirmation upon request documentation that your organization reviews the OIG/GSA exclusion lists upon initial hire/contract and monthly thereafter.

- Database (site listed below) verification is a mandatory **monthly requirement** and **must be completed on or before the end of each month.** Please attest below and fax completed attestation to (714) 947-8708.

The How To: Participation in Federal Programs Verification and Attestation can be found on our website at **www.healthsmartmso.com.**

Please be advised that pursuant to the terms of your agreement with our IPA, or an affiliated entity, you are required to comply with all applicable federal, state, and municipal rules and regulations and that this request is directly related to such provision. Please also be advised that such screenings are required under the contract between the IPA, or an affiliated entity, on the one hand, and the health plan, on the other hand.

To assist you with the implementation of your OIG/GSA Exclusion process, we are providing links to the relevant exclusions lists to comply with the regulations:

- Medi-Cal Suspended & Ineligible List- **https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**
- HHS OIG (Inspector General's Office in the Federal Government)- **https://exclusions.oig.hhs.gov/**
- System for Award Management (SAM)- **https://sam.gov/SAM/pages/public/searchRecords/advancedPIRSearch.jsf**

Please note that these three lists do not necessarily overlap and all three lists must be checked as to each employee, manager or downstream entity. For example, an employee could be listed on the Medi-Cal exclusion list but not listed on the OIG and/or SAM exclusion lists.

Print Name:	Name of Organization:	
Signature:	Date Signed:	National Provider:

As a reminder, a **monthly attestation for must be conducted and submitted.*

Please submit the Attestation by fax to (714) 947-8708 or via email at providerservice@healthsmartmso.com

We thank you for your continued support.

OneCare
CalOptima Health

OneCare Model of Care

2026

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Learning Objectives

- After completing the module, you will be able to:
  - Define OneCare and Model of Care (MOC).
  - Identify the four core elements of the OneCare MOC.
  - Describe eligibility for OneCare participation and identify specialized services for most vulnerable OneCare members.
  - Define Care Coordination, Health Risk Assessment (HRA), Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT).
  - Understand the essential role of the contracted network of providers, adherence to care standards and oversight.
  - Describe the Quality Measurement and Performance Improvement outcomes of the MOC.
  - Define how MOC effectiveness is measured.

Course Content

- OneCare Model of Care Overview
- OneCare Population
- Care Coordination
- Care Staff Roles and Responsibilities
- Key Components
  - Health Risk Assessment
  - Individualized Care Plan
  - Interdisciplinary Care Team
  - Care Transition Protocols
- Specialty Programs
- Evaluating the Model of Care

Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

Course Content (cont.)

- Communication Processes and Methods
- Updates to D-SNP - 2026

Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

OneCare
CalOptima Health

Overview

- The Centers for Medicare and Medicaid Services (CMS) require:
  - All Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC).
  - All employed and contracted personnel and providers of the MA D-SNP are to be trained on the MOC.
  - The OneCare MOC is CalOptima Health's "road map" for care management policies, procedures, and operational systems.
- This course describes the OneCare MOC and how CalOptima Health and the network of contracted providers work together to ensure the success of the MOC and enhance the coordination of care for the members.

What is OneCare?

- OneCare is:
  - CalOptima Health's Medicare Advantage Special Needs Plan
    - Also known as:
      - HMO-SNP
      - SNP-plan
      - D-SNP (Duals Special Needs Plan)
  - Serves people:
    - Eligible and enrolled in CalOptima Health for both Medicare and Medi-Cal (Medicaid) benefits
    - Residing in Orange County
    - Age 21 and older

Model of Care (MOC)

- A document required by Centers for Medicare and Medicaid Services (CMS) for a D-SNP
  - Defines the care management policies, procedures and operational systems for OneCare
  - Is "member-centric" with the ongoing focus on the member and the member's family/caregiver
- Four core elements are:
  - Population description of SNP
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement

OneCare Population

- OneCare population description includes:
  - Eligibility to participate
  - Health status and health disparities such as health status, where OneCare members live, living conditions, social and environmental context, and COVID 19 vulnerability
  - Demographics such as age, gender, race/ethnicity, language, and health disparities
  - Unique characteristics of the OneCare population

OneCare Population (cont.)

- Department of Health Care Services (DHCS) has identified specific populations who are eligible for California Integrated Care Management (CICM).
- OneCare identifies members eligible for CICM as the most vulnerable members.
- OneCare members who may meet the criteria for CICM and these members must be provided OneCare CICM case management services.
- OneCare is responsible for providing CICM services to members who are eligible and agree to enroll.

OneCare Population (cont.)

- OneCare's CICM populations include the following:
  - Experiencing or at risk for Homelessness
  - At risk for avoidable hospital or ED admission
  - Serious mental illness and/or Substance Use Disorder (SUD)
  - Transitioning from incarceration
  - At risk for institutionalization or long-term care
  - Transition to the community from institutionalization or long-term care
  - Pregnant or postpartum and subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality
  - Documented Dementia needs

OneCare Population (cont.)

- OneCare's most vulnerable members also include members with serious illness eligible for palliative care (Medi-Cal disease-specific criteria)

Knowledge Check

1. What does the acronym OC MOC mean?
    a. Orange Coast Care Model of Orange County
    b. Open Care Coordinator Model of Orange County
    c. OneCare Model of Care
    d. OneCare Medicare Order for Care
2. Care coordination is one of the four core elements of the MOC
    a. True
    b. False

Knowledge Check (cont.)

3. OneCare vulnerable members include those who are:
    a. Eligible for palliative care
    b. Serious mental illness and/or Substance Use Disorder
    c. Documented dementia needs
    d. All of the above

Knowledge Check - Answers

1. c. OneCare Model of Care
2. a. True
3. d. All of the above

Care Coordination

- Care coordination includes:
  - Organization of member care activities
  - Sharing information among all the health care participants involved with a member's care
  - Achieving safer and more effective care
  - Closed-loop coordination of all benefits, including Medicare, Medi-Cal, LTSS
- Main goal of care coordination is:
  - To meet members' needs and preferences in the delivery of high-quality, high-value health care

Care Coordination (cont.)

- Care coordination components include:
  - Staff structure
    - Administrative, clinical, and oversight roles specific to OneCare including a Personal Care Coordinator (PCC)
  - Health Risk Assessment (HRA)
    - Assessment of the OneCare members' health and social needs
  - Face-to-Face Encounter
    - In-person or an interactive telehealth visit involving the OneCare member and a participant of their Interdisciplinary Care Team or CalOptima Health's case management team or designee

Care Coordination (cont.)

- Care coordination components include:
  - Individualized Care Plan (ICP)
    - A plan of care for the OneCare member based on information from the HRA
  - Interdisciplinary Care Team (ICT)
    - The ICT includes the member's PCP, Case Manager, and others, as appropriate. Each OneCare member has a care team to ensure care coordination occurs in a structured collaborative process. The team is involved in the creation and updates of the ICP. They may have formal meetings as needed to discuss the member's care, review the ICP and ensure care coordination occurs as appropriate.
  - Care transition protocols
    - Guidelines on how to manage the OneCare member across the care continuum

Staff Structure and Roles

- Organized to align with essential care management roles:
  - Administrative
  - Personal Care Coordinator (PCC)
    - At CalOptima Health
    - At contracted health networks
  - Clinical
  - Oversight

Administrative

- Manages:
  - Enrollment
  - Eligibility
  - Claims
  - Grievances and provider complaints
  - Information communication
  - Collection, analysis, and reporting of performance and health outcomes data

Personal Care Coordinator (PCC)

- At CalOptima Health
  - Administers the HRA for each member
    - Initial and annual
    - May be face-to-face, virtual, telephonic, or paper-based
    - Enters HRA responses into data platform for licensed health care professional to review
    - Note — HRA collection not delegated to the health networks
  - Conducts warm transfer calls of the member to the health network
  - Maintains knowledge of all benefits including Medicare, Medi-Cal, and LTSS

PCC (cont.)

- At a health network:
  - Member's point of contact and liaison between the member, provider, health network and CalOptima Health
  - Role:
    - Guides member in understanding and accessing their benefits with awareness of all Medicare, Medi-Cal and LTSS benefits
    - Schedules, facilitates, and participates in ICT meetings, as appropriate
    - Assists member with scheduling appointments, facilitate referrals
    - Assists with coordination of member's health care needs
    - Notifies member's care team of key events
    - Facilitates communication of ICP to Primary Care Provider (PCP) and other care team members, including member

Clinical Staff

Examples of clinical staff may include:

- PCP
- Registered Nurse (RN) Case Manager
- Licensed Clinical Social Worker (LCSW) or Masters in Social Work (or related degree)

Roles:

- Advocate for, inform and educate members
- Coordinate care
- Identify and facilitate access to community resources
- Educate members on health risks and management of illnesses
- Empower members to be advocates of their health care
- Maintain and share records and reports
- Assure HIPAA (Health Insurance Portability and Accountability Act) compliance

Oversight

- CalOptima Health and the health networks collaborate to support the MOC.
- Role:
  - Monitor MOC implementation
  - Evaluate effectiveness of the MOC
  - Assure licensure and competency
  - Assure statutory and regulatory compliance
  - Monitor contractual and delegated services
  - Monitor Interdisciplinary Care Teams
  - Assure timely and appropriate delivery of services
  - Assure providers use evidence-based clinical practice guidelines
  - Assure seamless transitions and timely follow-up

Health Risk Assessment (HRA)

- Process:
  - CalOptima Health PCC:
    - Administers initial HRA and annual HRA for each member
    - Uses a standardized HRA tool
      - Note — HRA completion is not delegated to health network
  - May be completed face-to-face, virtual, telephonic, or paper-based
  - Identified care needs are categorized into Care Domains:
    - Physical Health, Behavioral Health, LTSS, Access to Care, Care Coordination, and promotion of Self-Management/Health and Wellness Monitoring

HRA (cont.)

- Process (cont.):
  - Used by clinical staff to evaluate the medical, psychosocial, cognitive, functional needs, identify any engaged caregiver and caregiver support needs, and current services received with medical and behavioral health history
    - Caregivers should be actively engaged in the member's ICP and ICT.
  - Used to develop a member's Individual Care Plan (ICP) and inform the members' ICT.

Face-to-Face Requirement

- The main purpose of the face-to-face encounter is to promote and ensure OneCare members are seen and clinically assessed at least annually by their PCP or specialist serving as the PCP.
- OneCare is required to provide a face-to-face encounter for the delivery of health care or care management or care coordination services between the member and a member of their care team or the case management team.
- CalOptima Health will track and monitor OneCare members to ensure they have or are offered a face-to-face encounter at least annually.

Face-to-Face Requirement (cont.)

- CICM populations engage through in-person contact in alignment with member preferences.
- CICM services must provide in-person care management and outreach for Members identified as experiencing homelessness.
- CICM is delivered by trained case managers and care coordinators working directly with members in community settings, shelters, or other accessible locations.

Face-to-Face Requirement (cont.)

- In-person engagement includes the following:
  - Conducting assessments and care planning in the member's environment
  - Facilitating connections to housing-related Community Supports
  - Respecting member autonomy and ensuring voluntary participation in CICM

Individualized Care Plan (ICP)

- CalOptima Health ensures that all OneCare members have an 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.
- Includes prioritized, personalized and measurable goals to meet a member's specific needs
- Initial ICP for newly eligible OC members must have a completed ICP within 90 days of CalOptima Health enrollment.

ICP (cont.)

- 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.
  - Comprehensive assessments include any case management supplemental assessments such as additional case management assessments, the Benjamin Rose Institute Caregiver Strain Instrument, and the AD8 Dementia Screening Interview.

ICP (cont.)

- 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 goals.
- 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.

ICP (cont.)

- ICP must include non-contracted and carved-out services that address member needs and must facilitate referrals to the following:
  - Community Based Organizations
  - County mental health and SUD services
  - Housing and homelessness providers
  - Community Supports providers
  - 1915(c) waiver programs, including MSSP
  - LTSS programs, including IHSS and Community-Based Adult Services (CBAS)
  - Medi-Cal transportation to access Medicare and Medi-Cal services
  - Medi-Cal Dental benefits

ICP (cont.)

- Maintained in the clinical documentation platform.
- Considered part of the member's case management record and stored in accordance with HIPAA and in compliance with state, federal and HIPAA requirements.
- Shared with the member, PCP and applicable participants of the ICT initially and as part of the members ongoing care and coordination.

Interdisciplinary Care Team (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.

ICT (cont.)

- Ensure invitation of Community Supports provider to formal ICT meeting with member's consent.
- The ICT composition is determined based upon the member's medical condition and their responses to the HRA.
- All coordination and communication are documented in the clinical documentation platform, and the ICP is updated accordingly.

ICT (cont.)

- Formal vs. Informal ICT
  - All OC members have an Interdisciplinary Care Team
  - All OC members should have evidence of Informal ICT collaboration
    - Examples include:
      - Collaboration with the PCP and other Specialists
      - Input from members of the ICT into the ICP
  - Formal ICT meetings will be held for:
    - High Risk members
    - Any members enrolled in Care Coordination or Complex Case Management
    - Member identified in a vulnerable population including CICM
      - Palliative Care Agency must-participate in a Palliative Care ICT for those members enrolled in Palliative Care
    - If member or PCP requests

Composition of the ICT Meeting

- ICT composition is determined by member's needs and preferences

Core Participants:
• Member and/or designated representative • PCP assigned to member • Medical Director • Case Manager • Care Coordinator • Social Worker

Additional Participants:
• Behavioral health specialist • Pharmacist • Therapist (speech and/or physical) • Nutritionist • Appropriate specialist • Health educator • Disease management specialist • LTSS Liaison • Dementia Care Specialist • Palliative Care Provider • Community Supports Provider

Composition of the ICT Meeting (cont.)

- Vulnerable populations include the following:
  - At Risk for Avoidable Hospital or ED: the member's caregiver according to member preferences.
  - Experiencing Homelessness: Community Supports community-based case manager or housing provider if applicable.
  - Serious Mental Health and/or SUD Needs: the member's caregiver and behavioral health or substance use provider according to member preferences.
  - At risk for institutionalization/LTC: the member's caregiver according to member preferences.
  - Palliative Care: Members receiving Palliative Care will have a Palliative Care ICT.
  - Documented Dementia Needs: the member's caregiver and a trained Dementia Care Specialist.

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.
- OneCare Transition Program protocols are provided to all members to address transition needs and include assignment of a single point of contact to support a member through a transition event.

Care Transition Protocols (cont.)

- OneCare Transition Program includes but is not limited to the following objectives:
  - Early identification of risk
  - Utilization Management support, Case Management interventions and self-management coaching of members through transition events
  - Communication with the ICT, Practitioners and Providers, and member
  - Reduction of unnecessary emergency department use and unplanned transitions
  - Analyzing, tracking, and trending utilization and assessment data for process improvement opportunities

Care Transition Protocols (cont.)

- For transitions
  - Member receives outreach within two business days for screening or assessment and communication plan for ICP follow up.
  - Elements of the ICP are also shared between care setting providers within two business days of notification that a transition has occurred.
    - The Utilization Management Inpatient Review nurse, Care Coordinator or Case Manager are responsible for communicating with the member and or designee and health care setting teams regarding changes to the member's health status and ICP.

LTSS Liaison

- OneCare must have staff to serve as liaisons for the LTSS provider community to help facilitate member care transitions.
- These staff must be trained to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules.
- Staff serving as liaisons for the LTSS provider community must participate in the ICT, as appropriate.

Dementia Care Specialists

- OneCare has *Dementia Care Specialists* who have received intensive training through Alzheimer's Orange County.
- The training includes understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers.
- The Dementia Care Specialist must participate in formal ICT meetings for members with dementia.

Dementia Care Specialists (cont.)

- The care team for members with documented dementia care needs must include the member's caregiver and a trained Dementia Care Specialist to the extent possible and as consistent with the member's preferences.
- These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.
- The ICP should also include any referrals to Community Based Organizations such as those serving members with dementia (e.g. Alzheimer's organizations).

Palliative Care

- Palliative Care is available to OneCare members.
  - Eligibility criteria is outlined in the D-SNP Policy Guide.
    - D-SNP Policy Guide can be found at DHCS.ca.gov
  - Providers must be educated on the program and process to make referrals.
  - OneCare members enrolled in a Palliative Care program:
    - The Palliative Care Coordinator serves as lead Care Manager.
    - Palliative Care Agency must participate in a Palliative Care ICT.
    - Palliative Care is part of the member's care team.
    - The ICP is developed and updated by, and/or shared with the Palliative Care team as appropriate.

Dementia Care Aware

- The Dementia Care Aware training and resources are available to support providers when detecting cognitive impairment.
  - https://www.dementiacareaware.org/
- Face-to-Face encounters and/or responses to the HRA may indicate potential cognitive impairment.
  - Members should be referred to their providers for further diagnostic evaluation when appropriate.
  - Providers should conduct a full diagnostic workup when memory concerns are identified.

Continuity of Care

- May be telephonic requests from Member, Authorized Representative, or treating Providers.
  - Includes DME and Medical Supply Providers.
- Requests will be completed within:
  - 30 calendar days from request;
  - 15 calendar days if Member's medical condition requires immediate attention; or
  - 3 calendar days if there is risk of harm to the Member.
- Member notification within 7 calendar days of completion.

Continuity of Care (cont.)

- Must notify Member 30 calendar days before the end of the continuity of care period.
- Must allow the Member to continue treatment for up to the 12-month continuity of care period.

Knowledge Check

1. Who administers the initial HRA?
    a. Member's doctor
    b. Member's caregiver
    c. CalOptima Health PCC
    d. Member's care coordinator
2. Who develops the member's ICP?
    a. Member's care coordinator
    b. ICT
    c. Health network PCC
    d. Member's caregiver

Knowledge Check (cont.)

3. The purpose of care coordination is to organize and coordinate the member's care activities.
    a. True
    b. False

Knowledge Check - Answers

1. c. CalOptima Health PCC
2. b. ICT
3. a. True

OneCare Provider Network

- CalOptima Health:
  - Contracts with board-certified providers
  - Monitors network providers to assure they use nationally recognized clinical practice guidelines
  - Assures that network providers are licensed and competent through a formal credentialing review
  - Maintains a broad network of specialists that include palliative care, pain management, chiropractors and psychiatrists
  - Monitors network adequacy to ensure access to care
  - Provides training on OneCare MOC for the providers and those who routinely interact with OneCare members:
    - Assures provision and attestation of initial and annual MOC training

OneCare Provider Network (cont.)

- OneCare provider network includes:
  - Primary care providers
  - Specialized expertise:
    - Specialists
    - Hospitalists
    - Skilled nursing facility (SNF) providers
    - Allied health providers
    - Behavioral health providers
    - LTSS services of CBAS, MSSP, IHSS, LTC
    - Pharmacists
    - Community-based Palliative Care Providers
    - Ancillary providers
    - Community Supports

OneCare Provider Network (cont.)

- OneCare provider network includes:
  - Acute facilities
  - Dialysis centers
  - Specialty outpatient clinics
  - Residential Care facilities
  - Radiology and imagining facilities
  - Laboratory facilities
- Use of evidence-based clinical guidelines and care transition protocols
  - Formalize oversight of provider network adherence to nationally recognized care standards.

Evaluating the Model of Care

- CMS defines processes and tools to measure health care outcomes.
  - Purpose is to ascertain that health plans provide high-quality health care for their members.
- Processes include:
  - Quality measurement (QM)
  - Performance improvement (PI)

Evaluating the Model of Care (cont.)

- Methods include:
  - Quality Improvement Committee
  - Measurable goals and health outcomes measurements
  - Measuring patient experience of care
  - Ongoing performance improvement evaluation
  - Dissemination of SNP quality performance related to the MOC

Performance Measurement

- Uses standardized quality improvement measures to measure 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

Measurable Goals

- Evaluates measurable goals that:
  - Improve coordination of care
  - Appropriate utilization of services for preventative health and chronic conditions
  - Improve member experience
  - Enhanced care transitions across all healthcare settings and providers

Measurement of Effectiveness

- Evaluates measures of 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

- Supports the physician management of chronic conditions
  - Disseminates best practices, evidence-based guidelines
  - Shares provider tool kits to promote education and adherence

Communication Processes and Methods

- Utilizes an integrated system of communication for members and providers on both a scheduled and as needed basis
- Methods include:
  - Member newsletters
  - CalOptima Health website
  - Networking sessions
  - Conferences: face-to-face, telephonic, electronic
  - Committees:
    - Utilization Management Committee (UMC)
    - Quality Assurance Committee (QAC)
    - Member Advisory Committee (MAC)
    - Provider Advisory Committee (PAC)

Knowledge Check

1. CalOptima Health monitors network adequacy to ensure members have access to care.
    a. True
    b. False
2. Specialty programs or services for OneCare members include:
    a. Behavioral health
    b. Dialysis centers
    c. Pharmacists
    d. All of the above

Knowledge Check (cont.)

3. OneCare develops their own quality improvement measures to measure performance and health outcomes.
    a. True
    b. False

Knowledge Check - Answers

1. a. True
2. d. All of the above
3. b. False

Updates to OneCare - 2026

- Introduction of California Integrated Care Management (CICM) that replaced ECM-Like
  - Added population of Members with Documented Dementia Needs along with Medi-Cal ECM Populations of Focus

- Inclusion of vulnerable population of Members with serious illness eligible for palliative care

Model of Care Summary

- OneCare's Model of Care:
  - Defines and creates a comprehensive strategy and infrastructure for care of our members
  - Meets the unique needs of the dual-eligible population by:
    - Setting agency-wide strategic goals
    - Contracting with expert practitioners
    - Striving to meet each member's unique medical, psychosocial, functional and cognitive needs

Acronyms List

ADRD	Alzheimer's Disease and Related Dementias
CBAS	Community-Based Adult Services (formerly Adult Day Care)
CICM	California Integrated Care Management
CMS	Centers for Medicare and Medicaid Services
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
D-SNP	Dual Special Needs Plan
ECM	Enhanced Care Management
HEDIS	Health Care Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Risk Assessment

Acronyms List (cont.)

ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
IHSS	In-Home Supportive Services
LCSW	Licensed Clinical Social Worker
LTC	Long Term Care
LTSS	Long-Term Services and Supports
MAC	Member Advisory Committee
MA-SNP	Medicare Advantage Special Needs Plan
MOC	Model of Care
MSSP	Multi-Purpose Senior Services Program
PAC	Provider Advisory Committee

Acronyms List (cont.)

PCC	Personal Care Coordinator
PCP	Primary Care Physician
PI	Performance Improvement
QM	Quality Measurement
QAC	Quality Assurance Committee
RN	Registered Nurse
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SUD	Substance Use Disorder
UMC	Utilization Management Committee

Authorities

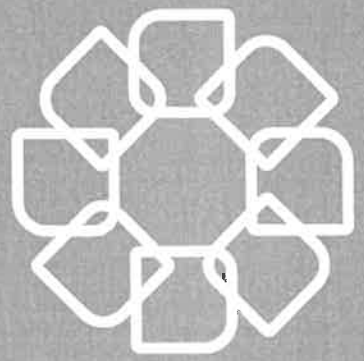
- H5433_2026 CalOptima Health D-SNP MOC_Off-Cycle

References

- CalOptima Health Policy GG.1204: Clinical Practice Guidelines
- CalOptima Health Policy EE.1103: Provider Network Training
- CalOptima Health Policy MA.6009: Care Management and Coordination Process
- CalOptima Health Policy MA.6021a: Continuity of Care for New Members
- CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment
- CalOptima Health Policy MA.6026: Coordination of Care, Medi-Cal Covered Services for OneCare

References (cont.)

- CalOptima Health Policy MA.6030: Transition of Care
- CalOptima Health Policy MA.6032: Model of Care
- CalOptima Health Policy MA.6040 First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements
- CalAIM Dual Eligible Special Needs Plans: Policy Guide – Contract Year 2026



OneCare

CalOptima Health

Stay Connected With Us

www.caloptima.org

@CalOptima

HEALTHSMART
MANAGEMENT SERVICES ORGANIZATION, INC.

Annual CalOptima Trainings - 2026

Submitting Organization/MSO Name:
HealthSmart Management Service Organization, Inc.

I have completed the following Annual Trainings for CalOptima:

CalOptima OneCare Model of Care Training 2026
CalOptima Cultural Competency Training 2026
CalOptima Disability Awareness Training 2026

Print Name: _____

Signature: _____

Date Completed: _____

5785 Corporate Ave., Cypress, CA 90630-5252
Post Office Box 6300, Cypress, CA 90630-0063
Phone (714) 947-8600 • Fax (714) 947-8702

Protecting Your Family's Health
Noble-Mid Orange County
888.880.8811

C/O HEALTHSMART MANAGEMENT SERVICES ORGANIZATIONS, INC.
Admin MAILING ADDRESS: P.O. Box 6300, Cypress, CA 90630-0063
Mailing Address: P.O. Box 6300, Cypress, CA 90630-0063
Live Operator Tel: (714) 947-8600 | Fax: (714) 947-8708

ACCESS AND AVAILABILITY STANDARDS

We are committed to ensuring patients receive health care services in a timely manner applicable for the patient's condition. Our access and availability standards are based on the Department of Managed Health Care (DMHC) regulatory and National Committee for Quality Assurance.

All Primary Care Physicians, Specialist are responsible for providing timely appointments and telephone access to all patients.

TELEPHONE ACCESS STANDARDS:
Non-Emergent member telephone messages to be returned within 24 hours. Urgent telephone calls must be returned by the physician or his "on-call" coverage immediately and/or within no more than 30 minutes. Members are encouraged to appropriately use the "911" emergency response system when they have an emergency medical condition which requires an emergency response. Clinical advice can only be provided by appropriately qualified staff (i.e., physician, physician assistant, nurse practitioner or registered nurse.)

If your office utilizes an answering machine After Hours, the following are suggestions for your message:

Hello, you have reached [insert Name of Doctor/Medical Group]. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest Emergency Room. If you wish to speak with the Physician On Call, please leave a message with your name, telephone number and reason for calling and your and you may expect a call back within 30 minutes.

Hello, you have reached [insert Name of Doctor/Medical Group]. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest Emergency Room. If you wish to speak with the physician on-call, you may reach directly by calling <telephone number> or press <number> to page the physician on call. You may expect a call back within 30 minutes.

Appointment ACCESS STANDARDS:

Medical Appointment Types	Standard
Timeliness of physician office telephone answer	Within < 30 second of the call
Timeliness of physician office response	Within the same business day of the call
PCP – Urgent Care not requiring Prior Authorization	Within < 48 hours of request
PCP – Urgent Care requiring Prior Authorization	Within < 96 hours of request
PCP – Routine/Non-Urgent Care	Within < 10 business days of request
PCP – Well Child Preventive Care	Within < 7 business day of request
PCP – Adult Preventive Care	Within < 20 business days of request
Specialist – Routine/Non-Urgent Care	Within < 15 business days of request
Specialist – Urgent Care not requiring Prior Authorization	Within < 48 hours of request
Specialist – Urgent Care requiring Prior Authorization	Within < 96 hours of Request
PCP – Office Wait Time	Within < 30 minutes from the appointment time
Appropriate after-hours emergency instruction	If this is a life-threatening emergency, please hang up and dial 911
Timely physician response to after hour phone calls/pages	Within < 30 minutes of request

AFTER HOURS SAMPLE SCRIPT

One of the following scripts may be used by physicians and medical groups as a template to ensure Health Net members have access to timely medical care after business hours or when your offices are closed.

IMPORTANT: Effective telephone service after business hours ensures callers are able to reach a live voice or answering machine within 30 seconds.

I. CALLS ANSWERED BY A LIVE VOICE (such as an answering service or centralized triage):

If the caller believes that he or she is experiencing a medical emergency, advise the caller to hang up and call 911 immediately or proceed to the nearest emergency room/medical facility.

If the caller believes the situation is urgent or indicates a need to speak with a physician, facilitate contact with the physician by doing one or more of the following:

- Put the caller on hold momentarily and then connect the caller to the on-call physician
- Get the caller's number and advise him or her that a physician will return the call within 30 minutes (immediately send a message to physician)
- Give the caller the pager number for the on-call physician and advise the caller that the physician will call the member within 30 minutes, or direct the caller to the nearest urgent care center location
- If a caller indicates a need for interpreter services, facilitate the contact by accessing interpreter services

Examples:

Hello, you have reached the <answering service/centralized triage> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, please stay on the line and I will connect you.

Hello, you have reached the <answering service/centralized triage> for Dr. <Last name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the on-call physician, Dr. <Last Name> can assist you. Please <page/call> him/her at <telephone number>.You may expect a call back within 30 minutes.

II. CALLS ANSWERED BY AN ANSWERING MACHINE:

Hello, you have reached <insert Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on-call (select appropriate option):

- *Please hold and you will be connected to Dr. <Last Name>*
- *You may reach the physician on-call directly by calling <telephone number>*
- *Press <number> to transfer to our urgent care center. Our urgent care center is located at <urgent care center address> (Appropriate language options should be provided for the location.)*
- *Press <number> to page the physician on-call. You may expect a return call within 30 minutes*

Examples:

Hello, you have reached the <Name of Doctor/Medical Group> for Dr. <Last Name>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on-call, please leave a message with your name, telephone number and reason for calling, and you may expect a call back within 30 minutes.

Hello, you have reached <Name of Doctor/Medical Group>. If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. If you wish to speak with the physician on- call, you may reach him/her directly by calling <telephone number> or press <number> to page the physician on-call. You may expect a call back within 30 minutes.

If you have any questions, please contact HSMSO Provider Services at (714) 947-8600 or via email at providerservice@healthsmartmso.com.

Thank you for your continued support and providing quality service to our patients.

Provider or Provider Representative Acknowledgment of training and receipt of the Access and Availability Standards:

Provider or Provider Representative:

Name: _____
(Print First and Last Name)

Title: _____

Signature: _____

Training Date: _____

Provider/Group Name: _____
(Print | Office Stamp Accepted)

Provider NPI: _____



Orange County Health Authority
dba CalOptima Health

2025 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 2024)

Document maintained by: Fay Ho
CalOptima Health Director FWA

CalOptima Health - A Public Agency
505 City Parkway West | Orange, CA 92868 | www.CalOptimaHealth.org
Main: 714-246-8400 | TTY: 711

TABLE OF CONTENTS

I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION 3

II. DEFINITIONS 4

III. FWA TRAINING 4

IV. DETECTION OF FWA 5
- a. Data Sources 5
- b. Data Analytics 5
- c. Analysis and Identification of Risk Areas Using Claims Data 5
- d. Sample Indicators 7

V. FWA INVESTIGATIVE PROCESS 7
- a. Referral to Enforcement Agencies 8
- b. Findings, Response, and Remediation 8
- c. Cooperation with regulatory investigations or prosecutions 9

VI. ANNUAL FWA EVALUATION 9

VII. POLICIES AND PROCEDURES (P&Ps) 9

I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies. The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- 42 C.F.R. 438.608
- Applicable regulatory guidance

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

II. DEFINITIONS

Abuse ("Abuse") means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to a CalOptima Health Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the CalOptima Health Programs.

Fraud ("Fraud") means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Waste ("Waste") means the overutilization or inappropriate utilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. FWA TRAINING

FWA training is provided to all Board Members, contractors, and employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA in accordance with CalOptima Health Policy HH.2023: Compliance Training. First-tier, downstream and related entities (FDRs) are also required to complete FWA training. CalOptima Health's FWA training provides guidance to Board Members, employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Common types of member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima Health's requirement to train employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board Members, employees, contractors, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance

with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are

intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates, codes, names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- The insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the case management system;
- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership

- Review of member enrollment applications and other documents, as necessary;
- Review of applicable contracts and/or All Plan Letters (APLs);
- Discuss allegation and evidence collected with subject matter experts;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare or PACE programs.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- Schemes with large financial risk to CalOptima Health, or its members.

b. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, prepayment claim review, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims

will be employed, and other payment recovery actions will be taken. The SIU will track and trend the FWA allegation and investigation, including, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board Members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program

- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual FWA, Violations of Applicable Laws, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance and FWA Training Programs
- HH.2028: Code of Conduct
- HH.3012: Non-retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

PROVIDER RESPONSIBILITIES

This section applies to the following CalOptima programs:

Medi-Cal

Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) plays the central role in structuring care for CalOptima members. The PCP is the main provider of health care services for CalOptima members and is responsible for the delivery of health care to his or her assigned members. CalOptima's model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

RESPONSIBILITIES OF THE PCP

PCP responsibilities include, but are not limited to:

1. Provide care for the majority of health care issues presented by the member, including preventive, acute and chronic health care.

2. Furnish risk assessment, treatment planning, coordination of medically necessary services, referral, follow up and monitoring of appropriate services and resources required to meet the needs of the member.

3. Case manage assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department, maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.

4. Assure access to care 24 hours a day, seven days a week, including accommodations for urgent care, performance of procedures and inpatient rounds.

5. Coordinate and direct appropriate care for members, including:
    a. Initial assessments
    b. Preventive services in accordance with established standards and periodicity schedules as required by age and according to the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF)
    c. Second opinions
    d. Consultation with referral specialists
    e. Follow-up care to assess results of primary care treatment regimen and specialist recommendations
    f. Special treatment within the framework of integrated, continuous care

6. Coordinate the authorization of specialist and non-emergency hospital services for members.

7. Contact and follow up with the member when the member misses or cancels an appointment.

8. Record and document information in the member's medical record, including:
    a. Member office visits, emergency visits and hospital admissions
    b. Problem lists, including allergies, medications, immunizations, surgeries, procedures and visits
    c. Efforts to contact the member
    d. Treatment, referral and consultation reports
    e. Lab and radiology results ordered by the PCP

9. A physician must countersign and date a sample of, at minimum, five percent (5%) of the medical records within thirty (30) calendar days of the date of treatment by the PA, NP, CNP. For services rendered by a CNM, a physician countersignature is not required.

10. A physician must review, countersign, and date any Schedule II drugs ordered by the PA, within seven (7) calendar days. When Schedule II drugs are furnished by an NP, CNP, and/or CNM a countersignature by a physician is not required. The NP, CNP and/or CNM shall adhere to the provisions of their standardized procedures when furnishing Schedule II drugs to address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

11. Make reasonable attempts to communicate with the member in the member's preferred language, using available interpretation or translation services.

12. If the member has a behavioral health diagnosis, coordinate the member's care with the member's behavioral health provider or behavioral health case manager.

CalOptima Policies and Procedures:

GG.1110: Primary Care Practitioner Definition, Role and Responsibilities

This section applies to the following CalOptima programs:

OneCare (HMO SNP),

Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) plays the central role in overseeing the care for CalOptima members. The PCP is the main provider of health care services for OneCare members and is responsible for the delivery of health care to his or her assigned members. CalOptima model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

RESPONSIBILITIES OF THE PCP

PCP responsibilities include, but are not limited to:

- Provide care for the majority of health care issues presented by the member, including preventive, acute and chronic health care.
- Furnish appropriate care for the health care problems presented by a member, including preventive, acute and chronic health care, and provide referrals to other practitioners for services.
- Provide risk assessment, treatment planning, coordination of medically necessary services, referral, follow up, and monitoring of appropriate services and resources required to meet a member's health care needs.
- Assure access to care 24 hour a day, seven days a week, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency and back-up coverage in the PCP's absence.
- Provide basic medical case management to assigned members:
    a. Ensure continuity of care for the member and an interactive relationship between the PCP and the member.
    b. Initiate and maintain in the medical record an individualized care plan (ICP) that addresses areas identified through the comprehensive assessment.
        i. The PCP participates on the 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. Increase member satisfaction.
    e. Facilitate access to appropriate health services.
    f. Ensure appropriate use of specialty and hospital services.
    g. Ensure the appropriate use of the pharmacy and drug benefit, including medication reconciliation.
    h. Screen health status, monitor and provide preventive health services.
    i. Identify and provide appropriate health education to improve a member's understanding of the importance of a healthy lifestyle and disease-specific interventions.
- Verify eligibility of the member at the time services are provided.
- Keep office waiting times to a maximum of 45 minutes.
- Coordinate and direct appropriate care for members, including:
    a. Review of the comprehensive Health Risk Assessment (HRA) that is completed within 90 calendar days after enrollment in OneCare and schedule an appointment for high-risk members within 30 calendar days.

   b. Provide preventive services in accordance with established standards and periodicity schedules, as required by age and according to the United States Preventive Services Task Force (USPSTF), the American College of Physicians (ACP), the American Academy of Family Medicine (AAFM), and relevant indicators of deficits.
   c. Provide second opinions as necessary.
   d. Consult with referral specialists (including providing necessary history and clinical data to assist the specialists with their examination of the member).
   e. Provide follow-up care to assess results of the primary care treatment regimen and specialist recommendations.
   f. Provide special treatment within the framework of integrated, continuous care.
- Coordinate the authorization of specialist and non-emergency hospital services for a member and ensure that services generated from referrals are initiated within 30 calendar days after the visit at which the referral was made.
- Assure the provision of basic clinical services including primary evaluation and treatment of acute and chronic medical and surgical problems in all systems.
- Contact and follow up with the member when the member misses or cancels an appointment.
- Record the following information in the medical record and make records available for review upon request by CalOptima, the member's health network, and applicable federal and state oversight agencies:
   a. Member office visits, emergency visits and hospital admissions
   b. A problem list that includes allergies, medications, immunizations, surgeries, procedures and visits
   c. Efforts to contact a member
   d. Treatment, referral and consultation records
   e. Laboratory and radiology results ordered by the PCP
   Individualized Care Plan (ICP)
- Adhere to the following to ensure that the member's medical record documentation is accurate:
   a. The documentation of each encounter includes the reason for encounter and relevant history, physical examination findings, and prior diagnostic test results, assessment, clinical impression, or diagnosis, medical plan of care, date and legible identity of the rendering provider.
   b. The current procedural terminology (CPT) and current International Classification of Diseases (ICD) codes reported on the health insurance claim form or billing statement supported by the documentation in the medical record
- Facilitate and ensure quality of care by establishing procedures to contact a member when the member misses an appointment that requires rescheduling for additional visits and following up on referrals to a specialist for care.
- Assist the member with the grievance and appeals processes as set forth in CalOptima policies.
- Coordinate the transfer of the member and his or her medical records to another provider upon notification of a planned or unplanned transition of care episode, or upon request by the member, the member's health network or CalOptima.
- Make reasonable attempts to communicate with a member in the member's preferred language, using interpretation or translation services available through a member's health network.
- Preserve the dignity of the member.
- If the member has a behavioral health diagnosis, coordinate the member's care with the member's behavioral health provider or behavioral health case manager.

CalOptima Policies and Procedures:
GG.1110: Primary Care Practitioner Definition, Role and Responsibilities
MA.9001: Complaint Process
MA.9002: Member Grievance Process
MA.9003: Standard Service Appeal
MA.9004: Expedited Service Appeal
MA.9005: Payment Appeal
MA.9006: Provider Grievance Process
MA.9007: Appeal Process for Member Discharge from Inpatient Facility
MA.9008: Appeal Process for Coverage Termination of SNF, Home Health, or CORF services Payment

Policy:	GG.1110
Title:	**Primary Care Practitioner Definition, Role, and Responsibilities**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/ Michael Schrader 03/25/2020*
Effective Date:	10/01/1995
Revised Date:	03/01/2021
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative ☐

I. PURPOSE

This policy defines the Primary Care Practitioner (PCP) role and responsibilities in providing Covered Services and Case Management to Members.

II. POLICY

A. A Member shall select a PCP or be assigned to a PCP as follows:

1. For Medi-Cal Members: In accordance with CalOptima Policies EE.1112: Health Network Eligible Member Assignment to Primary Care Provider, or AA.1207a: CalOptima Auto Assignment.

2. For OneCare Members: In accordance with CalOptima Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification.

B. A Member who selects or is assigned to a PCP shall receive Covered Services that are coordinated by his or her PCP or a Practitioner to whom he or she has been referred to by the PCP.

C. PCP requirements

1. A PCP shall be, enrolled as a Medi-Cal provider prior to having a contractual relationship with CalOptima or a Health Network.

2. A PCP shall be credentialed by each of his or her affiliated Health Network(s) or CalOptima in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners.

3. A PCP shall provide to a Member those authorized services that are within his or her scope of practice.

4. A PCP may limit his or her practice to adult, pediatric, or a combination of both Member populations. Additionally, obstetricians and gynecologists may limit their practice to female Members.

5. A PCP shall have a broad-based education with training that is supported by demonstrated ability and experience in providing primary care, including ongoing participation in continuing medical education focused on primary care subjects.

6. A Specialty Care Provider (SCP) may function as a PCP if he or she meets the criteria above and is recognized as a PCP by his or her affiliated Health Network(s) or CalOptima.

D. PCP responsibilities include, but are not limited to:

1. Reasonable efforts to verify eligibility of the Member at the time services are provided;

2. Providing care for the majority of health care problems presented by a Member, including preventive, acute, and chronic health care;

3. Providing risk assessment, treatment planning, coordination of Medically Necessary services, referral, follow-up, and monitoring of appropriate services and resources required to meet a Member's health care needs, including coordination of care and referral for carved-out and linked services that are not the direct responsibility of CalOptima (e.g., mental health services, dental services);

   a. Behavioral Health Services shall be coordinated by the PCP in accordance with CalOptima Policies GG.1900: Behavioral Health Services and CMC.6033: Behavioral Health Assessment, Referral, Coordination, and Information

4. Providing medical Case Management to assigned Members in accordance with CalOptima Policies GG.1301: Comprehensive Case Management Process, MA.6009: Care Management and Coordination Process, and CMC.6032: Comprehensive Care Coordination, with the following medical Case Management goals:

   a. Ensuring continuity of care for a Member and an interactive relationship between the PCP and the Member;

   b. Increasing Member satisfaction;

   c. Facilitating access to appropriate health services;

   d. Reducing unnecessary referrals to Specialty Care Providers and reducing inappropriate emergency department utilization;

   e. Controlling inappropriate use of pharmacy and drug benefits;

   f. Screening health status, monitoring, and providing preventive health services;

   g. Identifying and providing appropriate health education to improve a Member's understanding of the importance of a healthy lifestyle and disease-specific interventions; and

h. Participating in Interdisciplinary Care Team (ICT) meetings, as appropriate, in accordance with CalOptima Policies GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management, MA.6032: Model of Care, and CMC.6032: Comprehensive Care Coordination.

5. Assuring the provision of the required scope of services to the assigned Members;

6. Assuring access to care twenty-four (24) hour per day, seven (7) days per week, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency and back-up coverage in the PCP's absence;

7. Ensuring effective communication regarding treatment, diagnosis, medical history, and health education by providing culturally, linguistically, and sensory appropriate services to Members, in accordance with CalOptima Policies DD.2002: Cultural and Linguistic Services, MA.4002: Cultural and Linguistic Services, and CMC.4002: Cultural and Linguistic Services;

8. Keeping office waiting times to a maximum of forty-five (45) minutes;

9. Coordinating and directing appropriate care for Members, including:

   a. An Initial Health Assessment (IHA) completed for Medi-Cal Members within one-hundred-twenty (120) calendar days after enrollment in CalOptima Medi-Cal, in accordance with CalOptima Policy GG.1613: Initial Health Assessment;

   b. A review of the Initial Health Risk Assessment (HRA) that is completed within ninety (90) calendar days after enrollment with OneCare and scheduled within thirty (30) calendar days if the Member is deemed in a high-risk category, in accordance with CalOptima Policies MA.6022: Initial and Annual Health Risk Assessment and
      M.6031: Health Risk Assessment;

   c. Adherence to evidence-based clinical practice guidelines reviewed, adopted, and disseminated by CalOptima;

   d. Second opinions as necessary;

   e. Consultation with a referral specialist (including providing necessary history and clinical data to assist the specialist in his or her examination of the Member);

   f. Follow-up care to assess results of the primary care treatment regimen and specialist recommendations; and

   g. Special treatment within the framework of integrated, continuous care.

10. Coordinating the authorization of specialist and non-emergency hospital services for a Member, and ensuring that such services generated from referrals are initiated within thirty (30) calendar days after the visit at which the referral was made;

11. Assuring the provision of basic clinical services including primary evaluation and treatment of acute and chronic medical and surgical problems in all systems;

12. Recording all appropriate information in the Member's Medical Record, in accordance with CalOptima Policy GG.1603: Medical Records Maintenance, and making records available for review upon request by CalOptima, the Member's Health Network, the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), the United States Department of Health and Human Services, and other applicable regulatory agencies and subcontractors;

13. Facilitating and ensuring Member quality of care by establishing procedures to contact a Member when the Member misses an appointment that requires rescheduling for additional visits, and following up on referrals to a specialist for care;

14. Using the CalOptima grievance and appeals procedures as set forth in CalOptima Policies HH.1101: CalOptima Provider Complaint and/or MA.9006: Provider Complaint Process;

15. Assisting Members in the use of the CalOptima grievance and appeals procedures as follows:

    a. For CalOptima Medi-Cal Members: As set forth in CalOptima Policies GG.1510: Appeals Process, HH.1102: Member Grievance, and HH.1103: Health Network Member Grievance and Appeal Process.

    b. For CalOptima OneCare Members: As set forth in CalOptima Policies MA.9001: Complaint Process, MA.9002: Member Grievance Process, and MA.9003: Standard Appeal.

16. Coordinating the transfer of a Member and related Medical Records to another Provider or Practitioner upon request by the Member, the Member's Health Network, or CalOptima;

17. Making all reasonable attempts to communicate with a Member in the Member's preferred language, including utilizing interpretation and/or translation services available through a Member's Health Network and/or CalOptima; and

18. Preserving the dignity of the Member.

E. A Provider or Practitioner shall not bill a Member for the provision of Covered Services in accordance with Title 22 of the California Code of Regulations, Section 51002.

F. A PCP shall accept contract fees as payment, or in absence of a contract, CalOptima rates.

G. A PCP shall participate in, and accept, continuing peer review of the medical or surgical services provided to the Member.

H. A PCP shall permit review of services provided to Members by the Health Network, CalOptima, DHCS, or its subcontractors, CMS or its subcontractors, and the U.S. Department of Health and Human Services.

I. CalOptima shall not prohibit, penalize, discourage, or otherwise restrict a PCP, acting within his or her scope of practice, from advising or advocating on behalf of a Member who is a patient of such

health care professional about:

1. The Member's health status;

2. The Member's medical care;

3. Treatment options, including;

    a. Any self-administered, alternative treatments, and

    b. The provision of sufficient information to the Member to offer an opportunity to decide among all relevant treatment options, including the right to refuse treatment

4. The risks, benefits, and consequences of treatment or non-treatment; or

5. The opportunity for the Member to refuse treatment, and to express preferences about future treatment options.

III. PROCEDURES

A. Services for Pediatric Members

1. All children under twenty-one (21) years of age shall receive periodic preventive health assessments in accordance with the most recent recommendations of the American Academy of Pediatrics (AAP). Required content of each preventive health assessment is detailed in the CalOptima Pediatric Preventive Services Provider Resource page and outlined in CalOptima Policy GG.1116: Pediatric Preventive Services. The requirements for each periodic preventive health assessment include:

    a. Comprehensive health and developmental history (including assessment of both physical and mental health development);

    b. Unclothed physical examination, including assessment of physical growth;

    c. Assessment of nutritional status;

    d. Vision screen;

    e. Dental screen, including inspection of mouth, teeth, and gums;

    f. Hearing screen;

    g. Provision of immunizations in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP);

    h. Laboratory tests appropriate to age, sex, and history;

    i. Tuberculin (TB) test according to the latest standards recommended by the Centers for Disease Control Guidelines for TB control. Provisions shall be made to read and record the result of each test;

j. Testing for sickle cell trait, when appropriate;

k. Blood lead testing, per current Child Health and Disability Prevention (CHDP) guidelines; and

l. Health education and anticipatory guidance appropriate to age and health status.

2. Pediatric PCPs shall participate in the Vaccines for Children (VFC) Program.

3. A PCP shall refer a Member three (3) years of age or older, to a dentist annually, or more frequently, if indicated.

B. Screening for Chlamydia

1. Sexually active female Members twenty-five (25) year of age and younger shall receive screening for Chlamydia in accordance with the USPSTF recommendations.

2. CalOptima and its Health Networks shall make reasonable attempts to contact identified Members to provide Chlamydia screening and shall document unsuccessful attempts to contact such Members.

3. A PCP shall document screening for Chlamydia in a Member's Medical Record in accordance with Section II.D.13 of this Policy.

4. A Member must be at least twelve (12) years of age to request testing or treatment for sexually transmitted diseases, without parental consent.

C. Services for Adult Members

1. Adults shall receive preventive care services according to the latest recommendations of the United States Public Health Service. Preventive care and service guidelines shall include:

a. Appropriate periodic physical examinations;

b. Immunizations based on ACIP recommended immunizations included on the Medi-Cal FFS contract drug list as a pharmacy benefit;

c. Counseling and health guidance;

d. Age and sex appropriate screening;

e. Diagnostic tests and laboratory services;

f. Recommendations and referrals for continuing or specialized care for a specific diagnosis; and

g. Recommendations for high risk groups (e.g., HIV, AIDS, Sickle Cell Disease, etc.).

2. A PCP shall document in a Member's Medical Record attempts to provide preventive screenings, receipt of such screenings, and results, or voluntary refusal of such services.

Documentation of declination of services includes:

a. A signed statement by the Member or the Member's Authorized Representative; or

b. Dated documentation of the Member's or Authorized Representative's response to an in-person or telephone contact.

D. Other Responsibilities

1. An obstetrical Practitioner shall complete the CalOptima Pregnancy Notification Report for a pregnant Member in accordance with CalOptima Policy GG.1702: Pregnancy Notification and Birth Outcome Reports.

2. A PCP shall inform a Member or the Member's Authorized Representative of the availability of the Supplemental Nutrition Program for Women, Infants, and Children (WIC) services and refer the Member to these services as needed.

3. A PCP shall refer a Medi-Cal eligible Member to Medi-Cal services that are not CalOptima Covered Services, as appropriate (e.g., Dental Services, Mental Health Services, CCS).

E. Delegation of Treatment Responsibility

1. The PCP shall ensure access to physician care for assigned Members twenty-four (24) hours per day, seven (7) days per week.

2. The PCP shall designate a back-up Practitioner and provide a mechanism for the Member to access the back-up Practitioner when he or she is unavailable to provide coverage to assigned Members.

3. Payment for the PCP's back-up coverage is the sole responsibility of the PCP.

4. Providers and Practitioners rendering Emergency Services, authorized services, or services that do not require prior authorization as defined by CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct Providers, and GG.1508: Authorization and Processing of Referrals, shall be paid contract fees as payment, or in the absence of a contract, CalOptima rates in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

5. If a Member requires continuing specialty care, the Member's PCP may request authorization for the specialist to provide ongoing care for a specified period of time. Authorization for services shall be processed in the same manner as any other referral for specialist services. The PCP shall retain responsibility for the Member as the PCP.

F. Use of Non-Physician Medical Practitioners

1. When a PCP employs a physician assistant (PA), nurse practitioner (NP), or certified nurse-midwife (CNM), the Non-Physician Medical Practitioner shall be supervised by the physician in the provision of care and directed according to Medi-Cal and/or Medicare regulations (as applicable), California state regulations, licensure requirements, and CalOptima policy.

2. The supervising physician shall have an appropriate certification from the Medical Board of

California to supervise a PA. The PA shall hold a current license to practice.

3. A NP or CNM shall hold a current professional license for the position and act according to the agreed upon protocols and interface requirements cited in California state regulations.

G. In the interest of program integrity and the safety and welfare of a Member, CalOptima, or a Member's Health Network, may introduce utilization controls, as necessary, at any time, and without advance notice to the PCP. Such changes shall take place immediately and shall be based upon review of trends and variations from expected patterns of resource utilization for the Membership. Examples of utilization controls may include, but are not limited to:

1. Use of increased intensity of review for any Provider or Practitioner identified as failing to maintain standards, including appropriate referrals, follow-up, and coordination of services.

2. Mandatory education of the Provider or Practitioner in managed care principles regarding wellness goals, preventive services, and pharmacy utilization.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. American College of Obstetricians and Gynecologists, District IX
B. California Business and Professions Code, §2056.1
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Network Service Agreement
F. CalOptima Policy AA.1207a: CalOptima Auto Assignment
G. CalOptima Policy CMC.4002: Cultural and Linguistic Services
H. CalOptima Policy CMC.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
I. CalOptima Policy CMC.6031: Health Risk Assessment
J. CalOptima Policy CMC.6032: Comprehensive Care Coordination
K. CalOptima Policy CMC.9001: Member Complaint Process
L. CalOptima Policy CMC.9002: Member Grievance Process
M. CalOptima Policy CMC.9003: Standard Appeal
N. CalOptima Policy DD.2002: Cultural and Linguistic Services
O. CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider CalOptima Policy
P. FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group
Q. CalOptima Policy GG.1116: Pediatric Preventive Services
R. CalOptima Policy GG.1301: Comprehensive Case Management Process
S. CalOptima Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive Case Management
T. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers

V. CalOptima Policy GG.1508: Authorization and Processing of Referrals
W. CalOptima Policy GG.1510: Appeal Process
X. CalOptima Policy GG.1603: Medical Records Maintenance
Y. CalOptima Policy GG.1613: Initial Health Assessment
Z. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
AA. CalOptima Policy GG.1702: Pregnancy Notification and Birth Outcome Reports
BB. CalOptima Policy GG.1900: Behavioral Health Services
CC. CalOptima Policy HH.1101: CalOptima Provider Complaint
DD. CalOptima Policy HH.1102: Member Grievance
EE. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
FF. CalOptima Policy MA.4002: Cultural and Linguistic Services
GG. CalOptima Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
HH. CalOptima Policy MA.6009: Care Management and Coordination Process
II. CalOptima Policy MA.6022: Initial and Annual Health Risk Assessment
JJ. CalOptima Policy MA.6032: Model of Care
KK. CalOptima Policy MA.9001: Complaint Process
LL. CalOptima Policy MA.9002: Member Grievance Process
MM. CalOptima Policy MA.9003: Standard Appeal
NN. CalOptima Policy MA.9006: Provider Complaint Process
OO. CalOptima Provider Manual: https://www.caloptima.org/EN/Providers/ManualsPoliciesAndResources.aspx
PP. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
QQ. Child Health and Disability Prevention (CHDP) Program Guidelines, California Department of Health Care Services: http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx
RR. Guide to Clinical Preventive Services, Williams and Wilkins
SS. Guidelines for Health Supervision, American Academy of Pediatrics
TT. Health and Safety Code §1367.69
UU. Joint Statement on Primary Care Providers: California Academy of Family Practice
VV. Title 17, California Code of Regulations (C.C.R), § 37000 et seq.
WW. Title 22, California Code of Regulations (C.C.R), § 51002 & 51340(e)(3)
XX. Title 28, California Code of Regulations (C.C.R), § 1300.67
YY. Title 42, Code of Federal Regulations (C.F.R), § 422.206

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Effective	11/01/1998	GG.1623	Practitioner-Patient Relationship	Medi-Cal
Effective	06/01/2005	MA.7012	Health Care Professional Advice to Members	OneCare
Revised	04/01/2007	GG.1623	Practitioner-Patient Relationship	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2009	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Effective	05/01/2010	MA.5010	PCP Definition, Role, and Responsibilities	OneCare
Revised	10/01/2012	MA.5010	PCP Definition, Role, and Responsibilities	OneCare
Revised	10/01/2013	MA.5010	PCP Definition, Role, and Responsibilities	OneCare
Revised	09/01/2014	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Revised	11/01/2015	GG.1110	PCP Definition, Role, and Responsibilities	Medi-Cal
Revised	02/01/2016	MA.5010	PCP Definition, Role, and Responsibilities	OneCare
Revised	12/01/2016	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal
Revised	04/01/2017	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare
Retired	04/11/2017	GG.1623	Practitioner-Patient Relationship	Medi-Cal
		MA.7012	Health Care Professional Advice to Members	OneCare
		MA.5010	PCP Definition, Role, and Responsibilities	OneCare
Revised	10/01/2017	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare
Revised	08/01/2018	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare
Revised	04/01/2019	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare
Revised	03/01/2020	GG.1110	Primary Care Practitioner Definition, Role, and Responsibilities	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009 Access by Member's Authorized Representative.
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services.
Case Management	Medi-Cal: A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation. OneCare: A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Health Risk Assessment (HRA)	Medi-Cal: A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life. OneCare: A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.
Individual Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a PCP in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other Providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
Member	An enrollee-beneficiary of a CalOptima program.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse Practitioner who provides primary care.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Provider	A physician, nurse, nurse mid-wife, nurse Practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, health maintenance organization, or other person or institution that furnishes Covered Services.

Term	Definition
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider. Beginning February 2011, Specialty Care Provider will be used in place of Specialist Physician.

SUBJECT: Medical Records Standards Review **Policy #:** MR1
DEPARTMENT: Quality Management/Medical Records

Effective Date: April 14, 1997
Last Revision Dates: February 2007
Last Review: January 2023

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To outline the organizational process for review of ambulatory medical records defining medical standards and ensuring compliance with medical record requirements. This process will be utilized to monitor medical records during the years in-between a Full Scope Facility Site Review.

POLICY:

The standards as prescribed by DHS and NCQA are used to monitor the provider's compliance with this medical record policy. The standards are scored by three categories: (1) Chart Maintenance, (2) Medical Care Documentation and (3) Health Maintenance. Health maintenance includes the preventative health, immunization and health education criteria established by NCQA, HEDIS ®, U.S. Preventive Health Task Force, The American Academy of Pediatrics and the CDC.

The Medical Records tool will be utilized to systematically review and assess medical records to ensure compliance with established standards of practice**.**

The Quality Management Committee or nurse will perform medical record of the primary care physician's records against the standards no less than biennially.

All sites with over 50 members or more, with two years of participation in the IPA are to be reviewed. For multiple site practices, only one site is audited with the other sites rotated thereafter.

The Quality Management Committee may elect to use this policy and tool for a yearly review of the primary care providers for Inter-rater Review and peer review compliance of the medical record standards.

For all reviews that score less than 80% a corrective action plan is required. The Quality Management Committee will review and make recommendations for correction.

Where the review does not demonstrate conformity with good professional medical practice and appropriate health management, the physician and case will be presented to the Quality Management Committee. The Committee may elect to perform a physician-to-physician peer review meeting to assist in corrective action.

The IPA does not delegate medical record review activities.

NOTE: This policy does not replace the Provider Facility Site audits for credentialing and recredentialing.

DEFINITIONS:

Biennially: Every two years.

Practice Site: An office or facility where one or more primary care physicians provide care or services.

Primary Care Physician: A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

PROCEDURE:

For individual office review:

A. A phone call is made to schedule the appointment with the provider followed by a letter sent via mail or fax to confirm the date and time of review. Attached to the letter will be a copy of the Medical Record tool and any applicable attachments.

B. Charts are not to be selected or pulled by the provider being audited prior to the audit date, unless specific charts have been requested.

C. The auditor will review a random selection of patient's seen in the last three months. A minimum of 10 charts will be reviewed.

D. An exit conference will be conducted on the day of the audit, to preview primary strengths and weakness. A draft copy of the results will be provided to the provider during the exit conference.

E. The auditor will score, summarize the results including any necessary corrective action and follow up recommendations and send the original audit tool and report to the Quality Management Committee within 7 days of completing the audit.

F. At the next scheduled meeting the Quality Management Committee will review the audits and provider further recommendations and actions for disposition of each audit. Specific trends will be noted for individual and group provider education.

G. All providers will receive a letter from the Quality Management Committee stating the score and findings. Those providers scoring below 80% will be requested to submit a corrective action plan within two weeks.

H. If the provider has not responded, a second letter will be sent allowing for two more weeks to respond. After those two weeks, if the provider has not responded the case will be returned to Quality Committee as a potential quality issue and sanction review. (See the Risk Management Potential Quality Issues and Sanctioning policy.)

I. The results of these activities will be kept in the provider's quality credentialing file for incorporation into the recredentialing process.

For Inter-rater reliability of PCPs medical records review - When the group elects to utilize this tool for their Inter-rater Review the following will occur:

A. All PCPs meeting the requirements will attend a special meeting in a private location bringing 10 files.

B. If the primary care provider is a general or family practice physician, he/she will bring 5 adult chart and 5 pediatric charts.

C. The PCP will give their files to another PCP within his/her scope of practice.

D. Each participant is given a review number that is used to keep confidential the physician whose files are being reviewed and who did the review on the tool.

E. Each PCP will review another peer's files against the criteria listed on the tool.

F. A final summary of the findings is completed and written in the note section of the tool.

G. The QM Chairman will conduct a final discussion of findings and each participant has the opportunity to discuss medical record activity, findings and make recommendations. Specific trends will be noted for individual and group provider education.

H. For any physician who scores less than 80%, a follow up review of the medical records may be arranged as part of corrective action.

I. The results of these activities will be kept in the provider's quality credentialing file for incorporation into the recredentialing process.

FORMS:

IPA Medical Record Review Tool

REFERENCES:

Medical record guidelines identified by: NCQA, HEDIS ®, U.S. Preventive Health Task Force, The American Academy of Pediatrics and the CDC.

SUBJECT: Medical Records Screening Criteria **Policy #:** MR2
DEPARTMENT: Quality Management/Medical Records

Effective Date: January 1, 2000
Last Revision Dates: February 2007
Last Review: January 2023

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define Medical Records Screening Criteria for ensuring compliance with medical record requirements.

POLICY:

The standards, as prescribed by DHCS and NCQA, are used to monitor the provider's compliance with the medical record policy.

The Medical Records Screening Criteria identified in this policy will be utilized by providers to maintain Standards of Compliance.

A copy of the Medical Record Screening Criteria will be placed in each Primary Care Physicians Provider manual

DEFINITIONS

CMA: California Medical Association

DHCS: Department of Health Care Services

NCQA: National Committee for Quality Assurance

Primary Care Physician or PCP: A physician responsible for supervising, coordinating, and providing initial and primary care to patients; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

PROCEDURE:

A. Patient Identification: Each page of the chart must include a unique identifier that may include patient ID number, medical record number, first name, and last name. (NCQA)

B. Individual Record: Each patient must have his or her own record.

C. Personal Data: Information must include name, address, DOB, home, work or contact number. Beeper number is also sufficient. (DHCS)

D. Emergency Contact: For children, the parent's home /work number or anywhere parents can be reached is sufficient. For adults, the number of a friend or relative, beeper number or any number where a contact may be reached, and/or a message left is sufficient. (DHCS, NCQA)

E. Primary Language: The patient's primary language must be conspicuously documented on the medical record.

F. Interpreter Services: Interpreter services for non-English-speaking and/or hearing-impaired patients must be offered at each visit, and the offer of interpreter services must be documented in the medical record. If the patient refuses interpreter services, the refusal of interpreter services must also be documented in the medical record.

G. Allergies: Each record must have an allergy notation in a prominent and consistent place. If a patient has no allergies, this must also be clearly noted. "NKDA", "NKA" and "Ø" are all acceptable notations. (DHCS, NCQA, Title 10)

H. Chronic Significant Problem List: A separate list of all the patient's chronic significant problems must be maintained. A chronic problem is defined as one that is of a long duration, shows little change or is of slow progression. Absence of chronic problems must be noted on the chronic problem list. (DHCS, NCQA)

I. Chronic Continuing Medication List: Medications should be listed on a medication list and updated necessary with dosage changes and the date change was made. All medications, prescribed and over-the-counter, taken on an ongoing basis, must be noted on the medication list. The drug, dose, route, duration, and quantity of all prescribed medications must be noted. Ongoing medications that have been discontinued since the last visit should be noted on the medication list. Absence of ongoing medications must be noted on the medication list or every progress note. (CMA Guidelines, DHCS)

J. Chart Legibility: Charts must be legible to someone other than the writer. A record that is deemed illegible to the reviewer should be evaluated by a second person. (DHCS, NCQA, CMA Guidelines)

K. Informed Consent: Physicians must document their instructions to the patient regarding any suggested invasive procedure, making note of the alternatives to the proposed procedure, any risk involved in the procedure and the patient's understanding and agreement to the planned procedure. An invasive procedure is defined as surgical entry into tissues, cavities or organs or repair of major traumatic injuries. (CMA Guidelines)

L. Provider Signature/Title, each entry: An individualized identification of the author including his/her title must follow each entry into the medical record, whether the entry is handwritten or dictated. Initials are acceptable if a full signature and title is evident in the chart. (DHCS, NCQA, Title 10, CMA Guidelines)

M. Initial Comprehensive History: This maybe an initial self-assessment or history and physical done by the provider. On the initial visits there must be evidence that the patient has been questioned regarding: past surgeries, serious accidents, injuries, psychosocial history, medical history, presence of medical

problems, or illnesses, etc. within 120 days of eligibility with the health plan. (DHCS, NCQA, Title 10, CMA Guidelines)

N. Tobacco exposure: Smoking history for patients 12 years and older should be documented somewhere in the record by the time the patient has been seen by the physician for a complete physical assessment, including chewing, snuff and exposure to passive smoke. (NCQA)

O. Alcohol and Substance Use/Abuse: Alcohol use and or other chemical substance use for patients 12 years and older should be documented somewhere in the record if the patient has been seen by the physician for a complete physical assessment. (NCQA)

P. Date of each visit: Each and every entry must be accompanied by a date (month, day, year). (DHCS, NCQA, CMA Guidelines)

Q. Reason for visit: Every visit must have a notation specifying the reason for the visit. (DHCS, NCQA, CMA Guidelines)

R. Physical Exam Relevant to Reason for Visit: Physical findings relevant to the visit must be documented. This includes both normal and abnormal findings, as well as vital signs. (DHCS, NCQA, Title 10, CMA Guidelines)

S. Diagnosis/Impression: The diagnosis identified during each visit should be documented defining the physician's conclusions. (NCQA, Title 10)

T. Treatment/Therapy ordered Appropriate for Diagnosis: Based on the chief complaints, physical exam findings and diagnosis, the treatment ordered is considered reasonable. (NCQA, Title 10, CMA Guidelines)

U. Studies ordered Appropriately: The studies ordered should be considered with the treatment plan as related to the documented working diagnosis.

V. MD Review of Studies: There must be evidence that the physician reviewed the results of diagnostic studies. Methods will vary, but often the physician will initial the lab report or mention it in the progress note. (NCQA, Title 10, CMA Guidelines)

W. Results Discussed with Patient/Parent: When diagnostic studies are ordered, it should be documented that the results have been conveyed to the patient or parent and any questions have been addressed (CMA Guidelines)

X. Appropriate Use of Consultants: If a problem is identified and is being treated repeatedly by the PCP with no improvement in outcome, a referral to an appropriate specialist should be considered. If the physician refers patients to a specialist without a comprehensive documented review of the problem, this should also be noted. (NCQA, Title 10, CMA Guidelines)

Y. Results of Consultations: When the patient is referred to and seen by a consulting physician for consultations there must be a copy of the results of the consult report and any associated diagnostic work up in the chart. Primary physician review of the consultation must be documented. If the PCP needed to take some action, this should be documented. (NCQA, CMA Guidelines)

Z. Problems from Previous Visits Addressed: Documentation must reflect that the physician provides continuous evaluation of problems noted in the previous visits. (NCQA, CMA Guidelines)

AA. Date of Next Visit: The progress notes for each visit should contain notations as to the specific time frame in which the patient should return in weeks, months or PRN. (NCQA, CMA Guidelines)

BB. Missed Appointments: If a patient has cancelled or is a "No Show" for an appointment, this should be noted in the medical record. Three follow up attempts are required. This procedure is to assure that the physicians are aware of visits that have been missed and to assure that the patients are scheduled for follow up as soon as possible or advised of the consequences of not completing the prescribed treatment. (DHCS, CMA Guidelines)

CC. Hospital Records: Pertinent inpatient records must be maintained in the official medical record. These records may include but are not limited to the following H&P, surgical procedure reports, ER reports, and any discharge summaries. For pediatric patients seen since birth by the PCP being audited, the L&D records should be in the charts including the newborn assessment. (DHCS).

DD. Staying Healthy Assessment: Documentation of age appropriate Staying Healthy Assessments given to Medi-Cal members. Documentation should include notation of Heath Education materials discussed and/or distributed.

FORMS:

Medical Record Audit Tool
Staying Healthy Assessment Forms

REFERENCES:

NCQA
DHCS

SUBJECT: Medical Record File Maintenance **Policy #:** MR3
DEPARTMENT: Quality Management/Office Policy and Procedures

Effective Date: June 6, 1997
Last Revision Date: June 8, 2021
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure confidentiality and provide guidelines for the retrieval, maintenance, and storage of medical records.

POLICY:

All contracted providers and office staff will adhere to the medical records screening standards.

All medical providers are expressly prohibited from negligent disposal of medical information and intentional sharing, sale or use of medical information for any purpose not necessary to provide health care services. Disclosure of medical information for purposes of encoding or encrypting data, governmental reporting and chronic disease management is permitted when authorized.

All medical providers and their staff are expressly prohibited from publicly posting or printing members' Social Security Numbers (SSN) on any sign-in sheet, card/letter or any other document for the purpose of accessing services or products.

All staff with access to records must sign and have a confidentiality agreement on file. This includes office staff and health plan or regulatory agency personnel requesting a review of medical records.

Designated medical records office personnel will have the responsibility to ensure that the files are organized and ensure member confidentiality and coordinate release of medical records when formally requested.

Members may have access to their medical records at anytime or grant permission for their records to be sent to another facility for any purpose by first signing a "Release of Medical Records Form" to grant such authorization. Members have the right to request their medical record to be amended or corrected.

Members have the right to authorize/deny release of PHI beyond use for treatment, payment or health care operations and are allowed to view all records, materials, and documents used in making a coverage determination.

Individuals are entitled to copies of their health information in electronic format from any health plan or health care provider that uses or maintains electronic health records. Medical information is released after member authorization and in accordance with applicable Federal or State law.

Providers are prohibited from requiring a patient, as a condition of receiving services, to sign an authorization, release or consent or waiver permitting the disclosure of any medical information, in accordance with requirements to maintain confidentiality.

Except when required by law, patients are afforded the opportunity to approve or refuse the release of identifiable personal information. This includes information provided via telephone such as lab results, etc.

All inactive records may be purged from the active files provided that a system to archive and retrieve records is in accordance with contract and regulatory mandates.

- All Medical Records, medical charts, prescription files and other documentation pertaining to medical and non-medical services rendered to members will be maintained according to health plan mandates.
    - Medi-Cal: minimum of 7 years, except for minors until the age of majority (21)
    - CMS/Medicare & Commercial: minimum of 10 years

REGULATORY REQUIREMENTS:

Providers must make the records maintained by the Provider, Medical Group and MSO, as required by CMS and DHCS and other regulatory agencies, available to CMS and DHCS and its agents, designees or contractors or any other authorized representatives of the state of California or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

The Medical Group and its Providers further agree that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the state Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Medical Group and Provider to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

The Medical Group and its Providers must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DHCS may require, in a manner that meets CMS and DHCS record maintenance requirements.

The Medical Group and its Providers must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and state requirements.

Per DHCS APL 17-006, Medi-Cal beneficiaries may request, free of charge, copies of all documents and records relevant to the NOA [Notice of Action/ Notice of Adverse Benefit Determination], including criteria or guidelines used.

DEFINITIONS:

Not applicable

PROCEDURE:

A. Storage

1. All records will be stored in one central place inaccessible to unauthorized persons. Each member will have an individual record. An alpha or numeric coding system, sometimes color-coded, will be used for organizing files.

2. The record is retrieved for the provider's review and documentation at each encounter. An exception may be made for unscheduled, walk-in and/or emergencies. After each encounter, the medical record is collected and returned to a predetermined area designated for physician review. This area shall be inaccessible for the patients.

3. Out cards or other form of tracking/logging the location of records will be maintained at all times for medical group practices.

4. Active Medical records will be maintained by the provider, in the provider's place of business for eligible members who have had one or more encounters.

5. Inactive records of members who have changed providers, disenroll, or lose eligibility must remain accessible for 10 years and to the age of majority (21) for minors[1].

6. Microfilm copies of the documents may be substituted for the originals with the prior written consent of the member's Health Plan, provided that the microfilming procedures are approved by the Health Plan as reliable and are supported by an effective retrieval system.

B. Consent to Release Medical Records

1. Members who request release of their medical records to themselves or another provider must sign a Medical Release Form.

    a. Members must be at least 18 years of age, or an emancipated minor.

    b. If a member is not known to office staff, identification in the form of a driver's license will be required.

    c. Telephone requests for release of written medical information will not be honored, even if the caller's voice is known to the site employee.

2. Other requests for Medical Records – no consent required.

[1] DHS, HCFA Requirement

a. Court summons

b. Billing purposes

c. Health care purposes such as resolving a grievance or an appeal

d. Health oversight activities

e. Lawsuits and other legal disputes

f. Law enforcement purposes

C. Purging Medical Records

1. Place purged medical record in a secure archival box and label box prominently, accordingly. (i.e., "Disenrollment Charts for Archives, etc.)

2. List all charts in each box on the receipt or release of patient record form. Document legibly.

3. Place one copy of the "receipt" in the box.

4. Retained a secured copy of the "receipt" for the provider's record system.

5. All Medical Records, medical charts, prescription files and other documentation pertaining to medical and non-medical services rendered to members will be maintained according to minimum regulatory requirements. It is suggested, but not required for all lines of business, that stored records be maintained in an active/inactive status for a minimum of 10 – 14 years; and 30 years for disability claims; unless instructed otherwise by an insurance carrier, an attorney or contract obligations.

FORMS:
Release of Medical Records

REFERENCE:
Health Insurance Portability and Accountability Act (HIPPA) of 1996

SUBJECT: Advance Directives **Policy #:** MR4
DEPARTMENT: Quality Management/Office Policy and Procedures

Effective Date: January 1, 2000
Last Revision Date: June 10, 2009
Last Review: January 2026

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To ensure that the providers assist members 18 years and older in their understanding of Advance Directives and maintain valid copy in members' file.

POLICY:
All providers will have an area in the member's file that indicates if the member has an Advance Directive. If the member has an Advance Directive, a copy must be in the medical record.

The Advance Directive Information (Patient Self-Determination Act) will be maintained in the IPA provider manual.

The physicians will abide by the California Natural Death Act (1991) which recognizes the following two Advance Directives:

- Durable Power of Attorney for Health Care (DPAHC)
- Declarations

An Advanced Directive allows a member's representative to manage care or treatment decisions when the member is incapacitated and unable to do so.

Medical care providers will comply with state law and is not required to provide care that conflicts with the member's Advanced Directive.

Providers will allow a member or member's representative to be involved in decisions about withholding. resuscitative services or declining/withdrawing life-sustaining treatment.

Staff are provided education on Advance Directives. Medicare law requires the organization to demonstrate that its staff has been educated on these rights.

DEFINTIONS:

Advance Directive: document that advises one's physician, family, and friends about health care preferences, including the types of special treatment one wants or does not want at the end of life, one's desire for diagnostic testing, surgical procedures, cardiopulmonary resuscitation, and organ donation.

Declaration: a signed document by an adult individual stating that he/she does not wish to receive life-sustaining treatment, (i.e., artificially administered nutrition and hydration) if the patient ever becomes terminally ill or permanently unconscious.

Durable Power of Attorney for Health Care (DPAHC): a signed, dated and witnessed document in which a person 18 years of age or older names a surrogate decision maker to make health care decisions on their behalf in the event of incapacity. Individuals may also specify which health care treatment(s) they want rendered or withheld (i.e., surgery or the provision of artificial nutrition and hydration).

PROCEDURE:

1. The provider is responsible to ensure that all members over 18 years of age are informed of Advance Directives.

2. The provider is responsible for ensuring that the medical record of all members over 18 years of age contains documentation, dated, and signed by the provider, that the member has been informed about Advance Directives.

3. The provider is responsible to ensure that any form utilized to indicate a member's wishes for end-of-life treatment and/or healthcare preferences are notarized or witnessed by two individuals that are not health care providers or employees of health care providers of which only one witness is a blood relative. It must meet this requirement to be considered valid.

4. The provider is responsible for maintaining a valid copy of the Advance Directive in the member's medical file.

FORMS:

Advance Health Care Directive

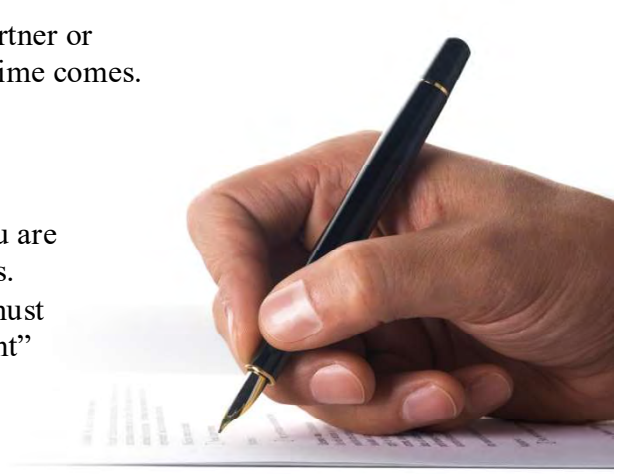
REFERENCES:

California Natural Death Act (1991)
Office of the Attorney General, State of California, Dept. of Justice
California Health Care Association

Advance Directives: What You Need to Know

What Is An Advance Directive?

- An Advance Directive is a document that states in writing your wishes about what type of care you would want or do not want, in case you get hurt, sick or become unable to make medical decisions for yourself.
- On the form, you may choose an adult relative, spouse, partner or friend as your "agent" to make these decisions when the time comes.
- You must sign your name and write the date on the form.



Where Do I Begin?

- You can write or fill out your own advance directive if you are 18 years or older, and are able to make your own decisions.
- You do not need a lawyer to fill out the document, but it must be signed by a notary public or by 2 witnesses. Your "agent" cannot be one of the witnesses.

Choose A Person You Trust.

- After you choose this person, talk to them in detail about what you want. Make sure this person knows your wishes and are willing to make them for you.
- Talk with your doctor and "agent" about what you want and give them both a copy.
- Your doctor may ask you to sign a form that states you have talked to them about this document.

Can I Change My Mind?

- You may change or cancel your advance directive at any time, as long as you are aware of how the choices impact your health care. Being aware means you can still think and voice your wishes in a clear manner. You can also change your "agent."
- Make sure that your doctor and your "agent" know about any changes.

Why Sign One Now When I'm Healthy?

- The best time to sign an advance directive is when you are healthy, and are able to think and speak for yourself. Having a plan in place will ensure that your wishes are followed.

Where Can I Get The Advance Directive Document?

- Most hospital emergency rooms and the Orange County Office on Aging have these forms. Call **1-800-510-2020** for more information. You do not need to use a form. You can also write your wishes down on paper and have this document signed instead.
- Contact Caring Connections at **www.caringinfo.org**.

CalOptima
A Public Agency
Better. Together.

PROVIDER COMPLAINT PROCESS

SUBJECT: Provider Grievances **Policy #: PR.1**
DEPARTMENT: Member Services

Effective Date: October 2003
Last Revision Date: January 2021

SCOPE:

This policy applies to all lines of business.

PURPOSE:

To define the process by which the IPA addresses and resolves Provider Complaints in accordance with applicable statutory, regulatory, and contractual requirements.

POLICY:

IPA shall establish and maintain a Grievance Process in which Providers may submit complaints for review and resolution.

The grievance process will address the receipt, investigation, and disposition of Provider Complaints and grievances according to statutory, regulatory and contractual requirements.

IPA will ensure prompt review and investigation of Complaints by management or supervisory staff responsible for the services or operations that are the subject of the Complaint.

IPA will ensure that Complaints are resolved within the timeliness requirements as set forth in this policy.

IPA shall not discriminate or retaliate against any Provider (including, but not limited to, terminating the Provider's contract) because such Provider filed a Complaint.

A provider complaint may be received up to 365 days after the date of an action for an individual claim billing dispute, or other dispute. In the case of inaction, receipt must be less than 365 days after the Time for Contesting or Denying Claims has expired.

IPA shall not charge a Provider for the cost of processing a Provider Complaint, and shall have no obligation to reimburse a provider for any costs incurred in connection with utilizing the Provider Complaint process.

IPA shall make available to the health plans and the applicable regulatory agency all records, notes, and documents regarding its Provider Complaint resolution mechanism(s).

Providers who seek to contest any decision made by IPA have the right to file a complaint with the health plan, and the right to a hearing with the health plan.

DEFINITIONS:

Claims Resubmission: The process by which a Provider requests the health plan to re-review an initial claim outcome.

Complete Claim: A claim that is submitted with all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided. Emergency Department physicians' claims will not require additional review by medical staff to be considered clean claims.

Complaint: A written statement indicating dissatisfaction with any aspect of the health network.

Complaint Acknowledgement Letter: A written statement acknowledging a receipt of a complaint/grievance.

Complaint Resolution Letter: A written statement explaining the resolution of a complaint/grievance based on the facts, information, and documentation.

Covered Services: Those medical services, equipment, or supplies that the IPAs/Medical Groups are obligated to provide under written agreements with regulatory agencies.

Grievance Process: The process by which IPA addresses and resolves all complaints.

Hearing Acknowledgment Letter: A written statement acknowledging a request for a hearing by the health plan with respect to the decision set forth in a Complaint Resolution Letter.

Last Date of Action: The date of last interaction and/or communication between the payor and the provider.

Pending Status Letter: A written statement prior to a resolution decision that documents the efforts taken to resolve the Complaint.

Provider: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who provides health care items or services.

Reasonably Relevant Information: That amount of objective, accurate information relevant to a disputed claim, generated by, or in the possession of the provider. This information, when reviewed by a trained, competent adjudicator would enable that person to determine the extent of IPA/Medical Group's liability, if any, and to comply with any governmental information requirements.

Time for Reimbursement: Thirty (30) calendar days for **Medi-Cal Program** after the date of receipt of the complete claim by the IPA, unless the complete claim or portion thereof is contested.

Utilization Management (UM) Appeal: A request for reconsideration of a UM decision to deny or modify a request for services based on medical necessity.

PROCEDURE

A. Submission of a complaint

1. Complaint will contain the following information:

   a. Provider name and identification number (Medi-Cal or tax identification)

   b. Contact information;

   c. Number assigned to original claim, if applicable;

   d. Clear description of disputed claim;

   e. Date of service;

   f. Clear explanation of the basis upon which the Provider believes the action is incorrect;

   g. With regards to a bundled group of substantially similar multiple claims, identification of the original claim number; and

   h. With regards to a dispute involving a member or group of members, name and identification number(s) of the member(s), a clear explanation of the disputed item(s), including the dates of service and the Provider's position on the issue.

2. Any complaint lacking the reasonably relevant information necessary to determine payor liability and that is in the possession of the Provider and is not readily accessible to IPA may be returned to the Provider within 30 calendar days. The returned Complaint shall clearly identify in writing the missing information. In no event shall IPA request the Provider to resubmit claim information that the Provider previously appropriately submitted as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the Provider.

3. A Provider may submit an amended Provider Complaint within thirty (30) Working Days after the date of receipt of a returned Provider Complaint that is missing required information.

4. Medi-Cal and Healthy Families providers that have furnished Covered Services to a Member for which the IPA is financially responsible for or is dissatisfied with any aspect of a health plans program, must file a Complaint with the IPA prior to filing a Complaint with the health plan.

5. A Provider may submit any such complaint to IPA no later than three hundred and sixty-five (365) days after the occurrence that precipitated the dissatisfaction, e.g. an adverse

action or decision that directly affects the Provider, or in the case of inaction, three-hundred-and-sixty-five (365) calendar days after the time for contesting or denying claims has expired.

B. Complaint Receipt and Resolution

1. Acknowledgment of Complaint

a. For **Medi-Cal and Medicare Providers**, within five (5) calendar days following the receipt of a Complaint, IPA will send the Provider a Complaint Acknowledgment Letter.

b. The Member Services Department will immediately log and record all Complaints in an electronic and hard copy Complaint file.

c. **Provider Complaints concerning requests to Dis-enroll Non-Compliant Members:** The IPA will forward such Complaints to the appropriate Health Plan.

(1) The Health Plan should send an acknowledgment letter within five (5) Calendar days from the receipt of your grievance.

(2) Within thirty (30) calendar days after the Health Plan has received the Grievance, you should receive a Provider Complaint Resolution Letter.

2. Investigation

a. The Member Services Department Staff will promptly investigate the Complaint and consult as appropriate with the IPA department(s) responsible for the services or operations that are the subject of the Complaint (i.e., Utilization Management, Claims).

b. Such department(s) will investigate the factual matter that are the subject of the Complaint and shall report factual findings and proposed resolution to the Member Services Staff within twenty (20) calendar days after initial receipt of the Complaint.

c. The IPA will use the Complaint Referral and Investigation Request form (attached) or a similar form to communicate and document findings and proposed resolutions.

3. Resolution

a. The Member Services Staff will review the factual findings along with relevant information including the proposed resolution.

b. Within thirty (30) calendar days after IPA has received the Complaint, the health network will send to the Provider a Complaint Resolution Letter or a Pending

Status Letter if the IPA is unable to resolve the issue within the thirty (30) day period following receipt of the Complaint.

c. If the IPA issues a Pending Status Letter, it will send a Complaint Resolution Letter to the Provider no later than sixty (60) calendar days after IPA has received the Complaint.

(1) The Pending Status Letter will include a description of the Complaint and identify a date on which a resolution can be expected.

(2) Upon resolution of such a Complaint, IPA will send a Complaint Resolution Letter to the Provider.

d. The Complaint Resolution Letter will describe the Complaint and provide a clear and concise explanation of the reasons for the decision, and describe the Provider's appeal rights.

4. Implementation of Complaint Resolution

a. IPA will take immediate action to implement the decision set forth in the Complaint Resolution Letter.

b. If the Complaint or amended Complaint is determined in whole or in part in favor of the Provider, the IPA shall pay:

i. Any outstanding monies that it determines to be due; and

ii. All interest and penalties required within five (5) Working Days after the date of the Complaint Resolution Letter pursuant to health plan policy.

c. Accrual of interest and penalties for the payment of any resolved Complaints shall commence on the day following the expiration of Time for Reimbursement.

C. Provider's Right to Appeal

1. Providers who are dissatisfied with the complaint resolution, have the right to contest any decision made by IPA/Medical Group, and have the right to file a complaint appeal with the health plan.

2. **A Medi-Cal Program Provider** may file an appeal with the health plan when they are not satisfied with the IPA's findings. The Complaint must be received by CalOptima no later than three-hundred-and-sixty-five (365) calendar days after the occurrence that precipated the initial Complaint, e.g., an adverse action or decision (e.g. initial claim denial or initial authorization denial or modification).

D. Provider's Right to Hearing

1. Request for Hearing

a. Right to a hearing: If a Provider has received a Complaint Resolution Letter from the health plan or health network, such Provider will have a right to a hearing if the Provider disputes:

1) Recoupement of funds based upon audit findings of overpayments;

2) The imposition of Sanctions or penalties; or

3) Suspension or termination of the Provider's participation in the health plan or a health network.

b. A Provider will not have the right to request a hearing for any other basis under this policy.

c. A Provider may submit to the health plans department designated to receive Complaints a written request for a hearing within fifteen (15) calendar days of the IPA or health plans issuance of a Complaint Resolution Letter.

d. The written request will give specific reasons for the hearing, including whether the Provider challenges:

1) The factual basis of the decision, and if so, the specific facts that the Provider disputes;

2) The legal basis for the decision; or

3) The reasonableness of the decision, Sanctions, or penalties imposed.

2. Hearing

a. The purpose of the hearing is to afford the Provider an opportunity to contest the factual or legal basis of the decision or the reasonableness of the decision, Sanctions, or penalties imposed.

E. Notices, Records, and Reports

1. IPA will include a reference to this policy in each Provider Contract.

2. IPA will maintain written records of each Complaint and shall include at minimum, the following information:

a. Provider name and identification number (Medi-Cal or tax identification);

b. Claim number (if applicable);

c. Member name;

d. Member ID# (CIN# preferred);

e. Date received;

f. Date of acknowledgement letter;

g. Date of resolution letter;

h. Type of complaint

i. Claim denial / no authorization

ii. Claim denial / submitted late

iii. Claim denial / incorrectly billed

iv. Claim payment not appropriate

v. Claim paid at lower level / ER down code

vi. Claim paid at lower level / lack of medical necessity

vii. Authorization denied / no medical necessity

viii. Authorization not appropriately obtained

ix. Operational / Contract dispute

i. Decision (overturn, upheld, partial)

j. Contract (yes/no)

k. Submitted electronic (yes/no)

3. IPA will maintain written records of each Complaint including copies of all Complaints and responses for a period of five (5) years following the termination of an IPA/Medical Group's contract with a health plan.

4. IPA will submit to the health plan, on a quarterly basis, and within thirty (30) calendar days after the end of each quarter, aggregate Complaint data in the format required by the health plan.

F. Other Provider Rights

In addition to any rights set forth in this policy and allowed by law, a Provider may resubmit a claim to IPA (prior to filing a Complaint related to payment of a claim), as appropriate in accordance with the Claims Processing and Settlement Practices policy.

FORMS

A. Complaint Form
B. Complaint Acknowledgment Letter
C. Complaint Resolution
F. Pending Status Letter

REFERENCES

A. Title, 28, CCR Section 1300.71.38(f)

CALOPTIMA ADDENDUMS

Provider Resources

- CalOptima Department and Program Contact Information

- Provider Resources on CalOptima's Website

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

B1: CALOPTIMA DEPARTMENT AND PROGRAM CONTACT INFORMATION

CALOPTIMA CONTACT INFORMATION

Contact Information	Phone Numbers and Website Addresses
CalOptima General Information	505 City Parkway West Orange, CA 92868 General: **714-246-8500** Claims: **714-246-8885** Authorizations: **714-246-8686** Website: www.caloptima.org TTY Line: **800-735-2929**
CalOptima PACE	13300 Garden Grove Blvd. Garden Grove, CA 92843 **714-468-1100** **855-785-2584** (toll-free)
CalOptima Website	www.caloptima.org
Provider Resource Line	**714-246-8600**
Case Management Department	**714-246-8686**
Claims: CalOptima Direct Claims Dual Eligible Claims (Crossover Claims)	P.O. Box 11037 Orange, CA 92856 **714-246-8885** P.O. Box 11070 Orange, CA 92856 **714-246-8885**

Claims Provider Dispute Resolution	P.O. Box 57015 Irvine, CA 92619 **714-246-8885**
Customer Service	**714-246-8500** or **888-587-8088** (toll-free)
Eligibility Verification	**800-463-0935** (toll-free) or **714-246-8540**
Compliance and Ethics Hotline	**877-837-4417**
Grievance and Appeals (Complaints)	505 City Parkway West Orange, CA 92868 **714-246-8554**
Health Education Referrals	**714-246-8500** or **888-587-8088** (toll-free) Fax: **714-338-3127** Email: healthpromotions@caloptima.org
Long-Term Care Authorizations	P.O. Box 11045 Orange, CA 92856 **714-246-8444**
Multipurpose Senior Services Program (MSSP)	**714-246-8500** or **888-587-8088** (toll-free)
Perinatal Support Services	**714-246-8686**
Prior Authorization/CalOptima Direct	**714-246-8686** or **888-587-7277** (toll-free)
Provider Data Management Services (PDMS)	P.O. Box 11033 Orange, CA 92856 **714-246-8468**
CalOptima Link	www.caloptima.org
MedImpact Healthcare Systems, Inc. (Pharmacy Benefit Manager)	Medi-Cal: 888-807-5705 (toll-free)
MedImpact Healthcare Systems, Inc. (Prior Authorizations)	Phone: 888-807-5705 (toll-free) Fax: 858-357-2557 (toll-free)

California Children's Services (CCS)	714-347-0300
Denti-Cal	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 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 Community Network	505 City Parkway West Orange, CA 92868	General: **714-246-8500** Claims: **714-246-8885** Authorizations: **714-246-8686** Website: www.caloptima.org TTY Line: **800-735-2929**
AltaMed Medical Group (SRG) Medi-Cal, OneCare	2040 Camfield Avenue Los Angeles, CA 90040	General: 866-880-7805 Claims: 866-880-7805 Authorizations: 888-747-2684 (toll-free) Website: www.altamed.org TTY Line: 714-246-8523
AMVI Care Health Network (PHC) Medi-Cal	600 City Parkway West Suite 800 Orange, CA 92868	General: 888-747-2684 (toll-free) 24 Hour: 888-747-2684 (toll-free) Website: www.prospectmedical.com
AMVI/Prospect (SRG) OneCare	600 City Parkway West Suite 800 Orange, CA 92868	General: 800-708-3230 (toll free) 24 Hour: 800-708-3230 (toll-free) Website: www.prospectmedical.com

Health Networks	Addresses	Phone Numbers and Website Addresses
Arta Western Health Network (SRG) Medi-Cal, OneCare,	1665 Scenic Ave. Suite 100 Costa Mesa, CA 92627	General: 800-780-8879 (toll-free) 24 Hour: 800-780-8879 (toll-free) Website: www.healthcarepartners.com
CHOC Health Alliance (PHC) Medi-Cal	1120 W. La Veta Ave. Suite 450 Orange, CA 92868	General: 800-424-2462 (toll-free) 24 Hour: 800-424-2462 (toll-free) Website: www.chochealthalliance.com
Family Choice Health Network (PHC/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.familychoicemedicalgroup.com
HPN-Regal Medical Group (HMO) Medi-Cal	8510 Balboa Blvd. Suite 285 Northridge, CA 91325	General: 800-747-2362 (toll-free) 24 Hour: 800-747-2362 (toll-free) Website: www.heritageprovidernetwork.com
Kaiser Permanente (HMO) Medi-Cal	393 E. Walnut Street Pasadena, CA 91188	General: 800-464-4000 (toll-free) 24 Hour: 800-984-4400 (toll-free) Website: www.kp.org
Monarch Family HealthCare (HMO/SRG) Medi-Cal, OneCare,	11 Technology Drive Irvine, CA 92618	General: 888-656-7523 (toll-free) 24 Hour: 888-656-7523 (toll-free) Website: www.monarchhealthcare.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
Prospect Medical Group (HMO) Medi-Cal	600 City Parkway West Suite 800 Orange, CA 92868	General: 800-708-3230 (toll-free) 24 Hour: 800-708-3230 (toll-free) Website: www.prospectmedical.com
Talbert Medical Group (SRG) Medi-Cal, OneCare,	1665 Scenic Avenue Suite 100 Costa Mesa, CA 92627	General: 800-297-6249 (toll-free) 24 Hour: 800-297-6249 (toll-free) Website: www.healthcarepartners.com
United Care Medical Group (SRG) Medi-Cal, OneCare,	600 City Parkway West Suite 800 Orange, CA 92868	General: 800-708-3230 (toll-free) 24 Hour: 800-708-3230 (toll-free) Website: www.unitedcaremedicalgrp.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): SRG is a physician group partner who accepts delegated clinical and financial responsibility for professional services for assigned members and enters into a risk sharing agreement with CalOptima for the hospital services. Please contact the member's assigned SRG for additional information regarding covered services.

Health Maintenance Organization (HMO): An HMO is a Knox-Keene licensed entity contracted by CalOptima to provide covered services to their assigned members. Please contact the member's assigned HMO for additional information regarding covered services.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

B2: PROVIDER RESOURCES ON CALOPTIMA'S WEBSITE

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

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

Covered Services & Services Covered by Other Agencies

- Covered Services Overview
- Early and Periodic screening, Diagnosis, and Treatment (EPSDT)
- Hospice Service Referrals
- Long Term Care Service Referrals
- Multipurpose Senior Services Program (MSSP)
- Long Term Services and Supports (LTSS)
- Pediatric Preventative Services
- Perinatal Support Services
- Vision Services
- Behavioral Health Services
- Dental Services
- Drug and Alcohol Abuse Services
- AIDS Wavier Services Referral
- Whole Child Model (WCM)
- Home and Community-Based Services Referrals
- Regional Center of Orange County Services

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

C1: COVERED SERVICES OVERVIEW

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

MEDI-CAL COVERED SERVICES ADMINISTERED BY CALOPTIMA

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

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

MEDI-CAL COVERED SERVICES NOT ADMINISTERED BY CALOPTIMA

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

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

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

ONECARE SERVICES OVERVIEW

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

OneCare Covered Services include, but are not limited to:

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

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

OneCare (HMO SNP)

CalOptima

A Public Agency

Better. Together.

OneCare Model of Care

Note: Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

Learning Objectives

After completing the module, you will be able to:

- Define OneCare and Model of Care (MOC).
- Identify the four core elements of the OneCare MOC.
- Describe eligibility for OneCare participation and identify specialized services for most vulnerable OneCare members.
- Define Care Coordination, Health Risk Assessment (HRA), Individual Care Plan (ICP) and Interdisciplinary Care Team (ICT).

Learning Objectives (cont.)

- Understand the essential role of the contracted network of providers, adherence to care standards and oversight.
- Describe the Quality Measurement and Performance Improvement outcomes of the MOC.
- Define how MOC effectiveness is measured.

Course Content

- OneCare Model of Care Overview
- OneCare Population
- Care Coordination
- Care Staff Roles and Responsibilities
- Key Components
  - Health Risk Assessment
  - Individual Care Plan
  - Interdisciplinary Care Team
- Specialty Programs
- Evaluating the Model of Care
- Communication Processes and Methods

Overview

- The Centers for Medicare and Medicaid Services (CMS) require:
  - All Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC).
  - All employed and contracted personnel and providers of the MA-SNP are to be trained on the MOC.
- The OneCare MOC is CalOptima's "road map" for care management policies, procedures, and operational systems.
- This course describes the OneCare MOC and how CalOptima and the network of contracted providers work together to ensure the success of the MOC and enhance the coordination of care for the members.

What is OneCare?

OneCare is:

- CalOptima's Medicare Advantage Special Needs Plan
  - Also known as:
    - HMO-SNP
    - SNP-plan
    - D-SNP
- Serves people:
  - Eligible for both Medicare and Medi-Cal (Medicaid) benefits
  - Residing in Orange County
  - Not qualified for the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Model of Care

- A document required by Centers for Medicare and Medicaid Services (CMS) for a D-SNP
  - Defines the care management policies, procedures and operational systems for OneCare
  - Is “member-centric” with the ongoing focus on the member and the member’s family/caregiver
- Four core elements are:
  - Population description of SNP
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement

OneCare Population

- OneCare population description includes:
  - Eligibility to participate
  - Social, cognitive and environmental factors; living conditions; and co-morbid conditions of members
  - Medical and health conditions impacting members
  - Unique characteristics of the population
  - Identification of the most vulnerable members of OneCare with specialized services listed for these members

OneCare Population (cont.)

- OneCare's most vulnerable members are the following special populations:
  - Frail and/or disabled
  - In need of disease management
    - Diabetes Mellitus (DM)
    - Congestive Heart Failure (CHF)
  - With behavioral health needs
  - Institutionalized
  - At end of life

Knowledge Check

1. What does the acronym OC MOC mean?
    a. Orange Coast Care Model of Orange County
    b. Open Care Coordinator Model of Orange County
    c. OneCare Model of Care
    d. OneCare Medicare Order for Care
2. Care coordination is one of the four core elements of the MOC
    a. True
    b. False
3. OneCare vulnerable members include those who are:
    a. Frail and/or disabled
    b. Have behavioral health needs
    c. Institutionalized
    d. All of the above

Knowledge Check - Answers

1. c. OneCare Model of Care
2. a. True
3. d. All of the above

Care Coordination

- Care coordination includes:
  - Organization of member care activities
  - Sharing information among all of the health care participants involved with a member's care
  - Achieving safer and more effective care
- Main goal of care coordination is:
  - To meet members' needs and preferences in the delivery of high-quality, high-value health care

Care Coordination (cont.)

- Care coordination components include:
  - Staff structure
    - Administrative, clinical, and oversight roles specific to OneCare including a Personal Care Coordinator (PCC)
  - Health Risk Assessment (HRA)
    - Assessment of the OneCare members' health needs
  - Interdisciplinary Care Team (ICT)
    - A team of medical, behavioral, and ancillary providers, plus the OneCare member and an authorized representative who convenes to manage the member's care and assure care coordination
  - Individual Care Plan (ICP)
    - A plan of care for the OneCare member based on information from the HRA
  - Care transition protocols
    - Guidelines on how to manage the OneCare member across the care continuum

Staff Structure and Roles

- Organized to align with essential care management roles:
  - Administrative
  - Personal Care Coordinator (PCC)
    - At CalOptima
    - At contracted health networks
  - Clinical
  - Oversight

Administrative

- Manage:
  - Enrollment
  - Eligibility
  - Claims
  - Grievances and provider complaints
  - Information communication
  - Collection, analysis, and reporting of performance and health outcomes data

Personal Care Coordinator

- At CalOptima
  - Administer the HRA for each member
    - Initial and annual
    - May be face-to-face, telephonic, or paper-based
    - Enters HRA responses into data platform for RN review
    - Note — HRA collection not delegated to the health networks
  - Communicate key event triggers to the health network
    - For example, significant changes in a member's medical condition
  - Conduct warm transfer calls of the member to the health network

PCC (cont.)

- At a health network:
  - Member's point of contact and liaison between the member, provider, health network and CalOptima
- Role:
  - Guide member in understanding and accessing their benefits
  - Schedule and participate in ICT meetings, as appropriate
  - Assist member with scheduling appointments, facilitate referrals
  - Assist with coordination of member's health care needs
  - Notify member's care team of key events
  - Facilitate communication of ICP to Primary Care Provider (PCP) and other care team members, including member

Clinical Staff

- Examples of clinical staff may include:
  - PCP
  - Registered Nurse (RN) Case Manager
  - Licensed Clinical Social Worker (LCSW)
- Roles:
  - Advocate for, inform and educate members
  - Coordinate care
  - Identify and facilitate access to community resources
  - Educate members on health risks and management of illnesses
  - Empower members to be advocates of their health care
  - Maintain and share records and reports
  - Assure HIPAA (Health Insurance Portability and Accountability Act) compliance

Oversight

- CalOptima and the health networks collaborate to support the MOC.
- Role:
  - Monitor MOC implementation
  - Evaluate effectiveness of the MOC
  - Assure licensure and competency
  - Assure statutory and regulatory compliance
  - Monitor contractual and delegated services
  - Monitor interdisciplinary care teams
  - Assure timely and appropriate delivery of services
  - Assure providers use evidence-based clinical practice guidelines
  - Assure seamless transitions and timely follow-up

Health Risk Assessment

- Process:
  - CalOptima PCC:
    - Administers initial HRA and annual HRA for each member
    - Uses a standardized HRA tool
      - Note — HRA completion is **not** delegated to health network
  - May be completed face-to-face, telephonic, or paper-based
  - Identified care needs are categorized into Care Domains:
    - Access, coordination of services, health monitoring, medical-acute, medical-chronic, behavioral health, long-term care and Long-Term Services & Supports (LTSS)
  - Used by clinical staff to evaluate the medical, psychosocial, cognitive, and functional needs with medical and behavioral health history
  - Used to develop a member's individual care plan (ICP)

Interdisciplinary Care Team

- Role and process:
  - Includes the member's medical, behavioral, and ancillary providers, plus the OneCare member and an authorized representative, if desired
  - Convenes to manage the member's care and assure care coordination
  - Analyzes and incorporates the results of the initial or annual HRA into the ICP, utilizing evidence-based guidelines
  - Collaborates to develop and annually, or as needed, update the member's ICP
  - Manages the medical, cognitive, psychosocial, and functional needs of each member
  - Communicates the ICP to all caregivers for care coordination
  - Provides a copy of the ICP to the member in the member's preferred language, font and print size

Composition of the ICT

ICT composition determined by member's needs

Core Participants:

- Member and/or designated representative
- PCP assigned to member

Additional Participants:

- Behavioral health specialist
- Pharmacist
- Case manager
- Health network PCC
- Therapist (speech and/or physical)
- Nutritionist
- Appropriate specialist
- Health educator
- Disease management specialist
- Social worker

Individual Care Plan

- Process:
  - Developed by ICT for each OneCare member
  - Includes the member's personalized goals and objectives, specific services and benefits and measureable outcomes
  - Goals and objectives prioritized by the member's preference
  - Written ICP communicated to member, caregivers and providers
  - Members and/or caregivers (at member request) given a copy of the ICP and asked to sign off
  - Written ICP reviewed and revised annually by PCP or ICT or when health status changes
  - Accessible to all care providers
  - Records maintained per HIPAA and professional standards

ICP Distribution

- The ICP will be signed by the member's PCP.
- The ICP **must** be shared with appropriate specialty providers and ICT participants.

Knowledge Check

1. Who administers the initial HRA?
   a. Member's doctor
   b. Member's care giver
   c. CalOptima PCC
   d. Member's care coordinator
2. Who develops the member's ICP?
   a. Member's care coordinator
   b. ICT
   c. Health network PCC
   d. Member's care giver
3. The purpose of care coordination is to organize and coordinate the member's care activities.
   a. True
   b. False

Knowledge Check - Answers

1. c. CalOptima PCC
2. b. ICT
3. a. True

OneCare Provider Network

- CalOptima:
  - Contracts with board-certified providers
  - Monitors network providers to assure they use nationally recognized clinical practice guidelines
  - Assures that network providers are licensed and competent through a formal credentialing review
  - Maintains a broad network of specialists that include palliative care, pain management, chiropractors and psychiatrists
  - Monitors network adequacy to ensure access to care
  - Provides training on OneCare MOC for the providers and those who routinely interact with OneCare members:
    - Assures provision and attestation of initial and annual MOC training

OneCare Provider Network (cont.)

- OneCare provider network includes:
  - Primary care providers
  - Specialized expertise:
    - Specialists, hospitalists, pharmacists, crisis teams
    - Skilled nursing facility (SNF)
    - Behavioral health providers
    - Allied health providers, ancillary services
    - Substance abuse detoxification and rehabilitation services
  - Use of evidence-based clinical guidelines and care transition protocols:
    - Formalize oversight of provider network adherence to nationally recognized care standards.

OneCare Programs and Services

- OneCare specialty programs and services include:
  - Behavioral health
  - Specialty services:
    - Dialysis
    - Transportation
    - Durable Medical Equipment (DME)
    - Home health
  - Psychosocial programs such as drug and alcohol treatment
  - Referrals to:
    - Community-Based Adult Services (CBAS)
    - In-Home Supportive Services (IHSS)
    - Housing assistance
    - Meals on Wheels
    - Personal finance counseling

OneCare Programs and Services (cont.)

- Disease management and health education programs
- Community-based resources, such as:
  - Aging & Disability Resource Connection of Orange County ADRCOC)
  - Multi-Purpose Senior Services Program (MSSP)
  - Office on Aging (OOA)
  - Dayle Mcintosh Center (independent living)

Evaluating the Model of Care

- CMS defines processes and tools to measure health care outcomes.
  - Purpose is to ascertain that health plans provide high-quality health care for their members.
- Processes include:
  - Quality measurement (QM)
  - Performance improvement (PI)
- Methods include:
  - MOC Quality PI Plan
  - Measureable goals and health outcomes measurements
  - Measuring patient experience of care
  - Ongoing performance improvement evaluation
  - Dissemination of SNP quality performance related to the MOC

Performance Measurement

- Uses standardized quality improvement measures to measure 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

Measurable Goals

- Evaluates measureable goals that:
  - Improve access to medical, behavioral, and social services
  - Improve access to affordable care
  - Improve coordination of care through an identified point of contact
  - Improve transitions of care across health care settings and providers
  - Improve access to preventive health services
  - Assure appropriate utilization of services
  - Assure cost-effective service delivery
  - Improve member health outcomes

Measurement of Effectiveness

- Evaluates measures of 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

- Supports the physician management of chronic conditions
  - Disseminates best practices, evidence-based guidelines
  - Shares provider tool kits to promote education and adherence

Communication Processes and Methods

- Utilizes an integrated system of communication for members and providers
  - Both scheduled and as needed
- Methods include:
  - Member newsletters
  - CalOptima website
  - Networking and focus group sessions
  - Conferences: face-to-face, telephonic, electronic
  - Committees:
    - Utilization Management Committee (UMC)
    - Quality Assurance Committee (QAC)
    - Member Advisory Committee (MAC)
    - Provider Advisory Committee (PAC)

Knowledge Check

1. CalOptima monitors network adequacy to ensure members have access to care.
   a. True
   b. False
2. Specialty programs for OneCare members include:
   a. Behavioral health
   b. Health education
   c. Durable Medical Equipment (DME)
   d. All of the above
3. OneCare develops their own quality improvement measures to measure performance and health outcomes.
   a. True
   b. False

Knowledge Check - Answers

1. a. True
2. d. All of the above
3. b. False

Summary

- OneCare's Model of Care:
  - Defines and creates a comprehensive strategy and infrastructure for care of our members
  - Meets the unique needs of the dual-eligible population by:
    - Setting agency-wide strategic goals
    - Contracting with expert practitioners
    - Striving to meet each member's unique medical, psychosocial, functional and cognitive needs

Acronyms List

- CBAS = Community-Based Adult Services (formerly Adult Day Care)
- CMS = Centers for Medicare and Medicaid Services
- QAC = Quality Assurance Committee
- HEDIS = Health Care Effectiveness Data and Information Set
- HIPAA = Health Insurance Portability and Accountability Act
- HN = Health Network
- HRA = Health Risk Assessment
- ICP = Individual Care Plan

Acronyms List (Cont.)

- ICT = Interdisciplinary Care Team
- LTSS = Long-Term Services and Supports
- MAC = Member Advisory Committee
- MOC = Model of Care
- PAC = Provider Advisory Committee
- PCC = Personal Care Coordinator
- PCP = Primary Care Physician
- SNP = Special Needs Plan
- UMC = Utilization Management Committee

Authorities

- H5433_2021_DSNP MOC final

References

- CalOptima Policy GG.1204: Clinical Practice Guideline
- CalOptima Policy EE1103: Provider Education and Training
- CalOptima Policy MA.6032: Model of Care


A Public Agency
CalOptima
Better. Together.


Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
A Public Agency
CalOptima
Better. Together.

-
-

This section applies to the following CalOptima programs:

Medi-Cal

C2: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT REFERRALS

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

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 for ASD, the provider should complete an Authorization Request and submit it to either CalOptima (if the member is in CalOptima 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 or the health network's prior authorization department.
5. If a provider has a member who requires BHT for autism spectrum disorder (ASD), the provider should refer the member to call CalOptima Behavioral Health at **855-877-3885.** This line is available 24 hours a day, seven days a week. TTY users can call **800-735-2929**.

CalOptima Policies and Procedures:

GG.1121: EPSDT Supplemental Services

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

C3: HOSPICE SERVICE REFERRALS

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

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

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

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

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

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

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

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

- **CalOptima Direct Medicare/Medi-Cal Members** — For CalOptima Direct Medicare-Medi-Cal members, Medicare covers hospice services, while CalOptima Direct only pays for hospice room and board services per Medi-Cal guidelines.

HOW TO MAKE A REFERRAL FOR HOSPICE SERVICES

1. If a member needs hospice services, a provider (primary care provider) should work with the member and the member's authorized representative to identify an appropriate hospice agency. Upon identifying an appropriate hospice agency, the provider should make the referral to the identified hospice agency.
2. If a member is in CalOptima Direct, and they are in a long-term care nursing facility, the hospice agency will submit a Notification/Validation form to CalOptima's Long-Term Services and Supports at **714-246-8843**. The Notification/Validation of Hospice services will be confirmed for hospice room and board.
3. If the member is dually eligible for Medicare and Medi-Cal, and the member is in a long-term care nursing facility, the hospice agency will submit the Notification/Validation form for room and board only to CalOptima's Long-Term Services and Supports at **714-246-8843**. The hospice provider will work with Medicare for the Medicare services.
4. For questions about hospice services, providers can call CalOptima Long-Term Services and Supports at **714 246-8444**.

CalOptima Policies and Procedures:

GG.1503: CalOptima Hospice Coverage Notification and Validation Requirements

This section applies to the following CalOptima programs:

Medi-Cal

C4: LONG-TERM CARE SERVICE REFERRALS

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

Types of Long-Term Care Facilities — Medi-Cal covered long-term care services include placement in the following types of facilities and Long-Term Services and Supports 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 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 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's website, which contains the list of CalOptima contracted facilities: www.caloptima.org
3. The admitting facility is responsible for obtaining authorization from CalOptima. The admitting facility will present medical justification for the level of care requested.

4. If the authorization request is not approved or is modified, the member, physician or facility has an option to appeal by submitting additional documentation. There are specific timelines to submit an appeal based on whether the denial was administrative or level of care.

    a. An administrative denial appeal is submitted to CalOptima's Grievance and Appeals 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 original decision.
    c. For more information on how to file an appeal, please see **Section R1: Provider Complaint Process.**

7. The CalOptima 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 the CalOptima Long-Term Care at **714-246-8444**.

CalOptima 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 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 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 (1D, 2D, 6D, 1E, 2E, 6E, 1X, 1Y, 10, 14, 16, 18, 1H, 20, 24, 26, 28, 60, 64, 66, 68, 6H)
- Not have a Medi-Cal share of cost
- Reside in Orange County
- Be able to be served within MSSP's cost limitations
- Be appropriate for care management services

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

- "Need for care management" means that the member requires assistance in accessing community services, maintaining or effectively using available services, 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 is able to provide care at a cost below what would otherwise be expended on nursing facility care and maintain the member in his or her home environment.

CASE MANAGEMENT AND COORDINATION OF CARE

- CalOptima and its affiliated health networks will work the CalOptima MSSP provider to provide case management and coordination of care for CalOptima members.
- CalOptima's MSSP provider will participate in the care management team that includes an Interdisciplinary Care Team (ICT) of health professionals.
- CalOptima informs its members about the CalOptima MSSP program and establishes a process to refer members who enrolled in Medi-Cal for Managed Long-Term Services and Supports (MLTSS) and are potentially eligible for the MSSP program to the MSSP provider for eligibility determination.

- CalOptima and the CalOptima MSSP provider will coordinate and work collaboratively on care coordination care activities for the MSSP member.
- CalOptima shall notify the CalOptima MSSP provider within five business days of a CalOptima member's disenrollment from CalOptima.
- CalOptima's MSSP providers will accept referrals from any sources including a CalOptima case manager, health networks, members, member's representative or caregiver, acute hospital care managers, nursing facilities, and/or other community-based organizations.
- Since MSSP's inception in 2001, CalOptima has contracted with the California Department of Aging to host the MSSP site. MSSP is budgeted and reimbursed through monthly reconciliation of CalOptima members who are enrolled in the program.
- CalOptima will verify the Medi-Cal eligibility and plan enrollment status of each MSSP member on a monthly basis.
- CalOptima and its health networks will identify, refer and provide care coordination for MSSP-eligible members.
- CalOptima will utilize the MSSP member's assessment data to develop an Individualized Care Plan (ICP) based on the member's risk, co-morbidity, complexity of medical condition and functional status.
- CalOptima will provide initial and ongoing training for the MSSP program being integrated into CalOptima as a managed care benefit.
- CalOptima and the CalOptima MSSP provider will maintain confidentiality of all member records and information.

APPEALS, GRIEVANCES AND COMPLAINTS PROCESS

- An MSSP member whose services have been denied, reduced, suspended or terminated from MSSP has the right to initiate a request for a State Hearing within 90 calendar days. At any time during this process, a member may submit a Withdrawal of Request for State Hearing Form.
- In the event a CalOptima member does not meet California Department of Aging (CDA) MSSP eligibility criteria 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
  PO Box 944243, Mail Station 19-37
  Sacramento, CA 94244-2430

  Or fax to 916-229-4110

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

- CalOptima MSSP provider shall issue a Notice of Action (NOA) for any adverse decisions regarding MSSP enrollment, or when a Waiver Service is denied, reduced, suspended or terminated by the MSSP provider. The NOA is mailed to a member informing of 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 MSSP provider's decision, he or she must complete and submit the Request for a State Hearing Form within 90 calendar days to the Office of the Chief Referee at the California Department of Social Services (CDSS).

- CalOptima MSSP provider shall retain the responsibility to receive, acknowledge, respond and track MSSP appeals, grievances and complaints, and manage the State Hearing process for MSSP waiver participants and CalOptima members receiving MSSP services.
- CalOptima Grievance and Resolution department shall manage appeals, grievances and complaints for non-related MSSP services for MSSP waiver participants, in accordance with CalOptima Policies CMC.9001: Member Complaint Process and HH.1102: CalOptima Member Complaint.
- CalOptima LTSS department shall be responsible for reporting MSSP appeals, grievances and complaints statistics and analysis to LTSS Quality Improvement (QI) Subcommittee on a quarterly basis.
- When a member files a timely appeal of CalOptima 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 Grievance and Appeals (GARS) department that an appeal was filed.

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

    1. Developing a written position statement in response to the appeal request
    2. Attending the hearing by telephone and
    3.Responding to questions and presenting additional information to the ALJ.

Upon the ALJ's rendering the final decision:

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

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

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

- The MSSP provider shall communicate any non-MSSP related appeals, grievances and complaints to GARS.
- The CalOptima GARS department shall communicate any MSSP related appeals, grievances and complaints that are received internally to MSSP provider.
- Upon receipt of member's appeal, grievance or complaint, CalOptima GARS department shall keep records using an internal tracking system such as: decisions, dates and resolutions.

HOW TO REFER A MEMBER TO MSSP

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

ROLE OF THE PHYSICIAN AND MSSP

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

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

CalOptima Policies and Procedures:

GG.1831: Multipurpose Senior Services Program (MSSP)

GG.1832: Multipurpose Senior Services Program (MSSP) – MSSP Identification, Referral, and Coordination of Care Process

GG.1834 Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process

This section applies to the following CalOptima programs:

C6: LONG-TERM SUPPORT SERVICES (LTSS)

OVERVIEW

CalOptima 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 (CBAS)

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

Community-Based Adult Services (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 in the Medi-Cal programs
- Must be at least 18 years of age or older
- Meet Nursing Facility-A (NF-A) level of care or above or
- Have an organic, acquired or traumatic brain injury or chronic mental health condition or
- Have moderate to severe cognitive disorder such as Alzheimer's disease or other dementia or
- Have mild cognitive impairment or
- Have developmental disabilities that meet Regional Center criteria and eligibility

CalOptima LTSS staff, contracted registered nurse, or Kaiser staff will perform a face-to-face (F2F) assessment of the member within 30 calendar days of receipt of the initial eligibility inquiry. CalOptima shall not require an initial F2F review when adequate documentation is available to make a determination that a member is eligible to receive CBAS. CalOptima LTSS clinical staff shall make CBAS eligibility 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 will deny the request and notify the member of the denial decision in writing through use of the Notice of Action or Integrated Notice of Denial that addresses members' right to file an appeal or grievance under state and federal law.

CBAS Authorization Process

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

- The completed CalOptima CBAS Authorization Request Form (ARF) to include the following information:
    a. A start and end date
    b. Total number of days requested per week
    c. Total number of days requested in a six-month period
    d. The member's individualized plan of care
- An authorization is required 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 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 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 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 MOU executed between CalOptima 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, face-to-face 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 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 or its health network providers will offer an ICT to all high-risk members to discuss a plan of care.

- CalOptima or health network providers shall coordinate with the county SSA IHSS social worker to participate in the member's interdisciplinary care team 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

CONTACT INFORMATION

For more information from CalOptima for CBAS or IHSS services (initial referrals only), contact Long-Term Support Services at **714-246-8444**. Providers may also access CalOptima 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 In-Home Supportive Services (IHSS), members may call Orange County In-Home Supportive Services (IHSS) 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 a conduct a needs assessment.

CalOptima 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 programs:

Medi-Cal

C7: PEDIATRIC PREVENTIVE SERVICES

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

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

To review the full AAP guidelines, please access the Providers section of CalOptima's website. CalOptima pays providers for PPS services on a fee-for-service basis at the same rate whether the members are in CalOptima Direct (COD) or enrolled in one of CalOptima's health networks. CalOptima's payment for PPS services is in addition to any payment issued by a contracted health network.

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

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 the CalOptima contracted health networks.

2. Providers must be registered with the Department of Health Care Services (DHCS).

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

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

4. Providers must complete the Staying Healthy Assessment tool at the appropriate age intervals. The Staying Healthy Assessment tool may be obtained in the Provider section of CalOptima's website. Physicians must participate in the Vaccines for Children (VFC) program. Providers are not required to be CHDP certified or be Board certified to participate in the VFC program. For more information, call the VFC program at 877-243-8832 or visit their website at: Vaccines for Children Program.

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 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's PPS coordinator at **714-246-8600** to obtain CMS 1500 or UB04 forms.

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

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

3. For patients NOT ELIGIBLE for CalOptima, **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 only pays the administration fee for each vaccine supplied by the VFC Program.

CalOptima Policies and Procedures:

GG.1116: Pediatric Preventive Services

This section applies to the following CalOptima programs:

Medi-Cal

C8: PERINATAL SUPPORT SERVICES

Perinatal Support Services (PSS) are enhanced services for CalOptima pregnant women provided through the CalOptima Bright Steps program. PPS are offered to pregnant members for the duration of their pregnancy and for at least 12 weeks postpartum. Services include, but are not limited to:

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

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

1. To obtain a copy of the PNR form, please visit the Providers section of CalOptima's website.
2. Providers should fax the completed PNR to the CalOptima PHM department at: **714-246-8677**.
3. To obtain more information about PSS or the Bright Steps program, call CalOptima's PHM department at **714-246-8895**

CalOptima Policies and Procedures:

GG.1701: CalOptima Perinatal Support Services Program

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP)

C9: VISION SERVICES

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

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

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

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

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

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

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

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

CalOptima Policies and Procedures:

GG.1111: Vision Services

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

C10: BEHAVIORAL HEALTH SERVICES

MEDI-CAL

Outpatient Behavioral Health Services

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

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

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

Behavioral Health Services at Long-Term Care Facilities

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

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

Behavioral Health Treatment

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

- Is under 21 years of age
- Meets medical necessity criteria
- Has a recommendation from a licensed physician, surgeon or a 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 Behavioral Health Authorization Request Form (BH-ARF) or Behavioral Health Treatment Authorization Form (BHT-ARF) and fax it to CalOptima Utilization Management for review and decision at **714-954-2300**.

ONECARE (HMO SNP)

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

- Inpatient mental health care
- Partial hospitalization services
- Outpatient mental health care
- Outpatient individual and group therapy for substance abuse

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

HOW TO MAKE A BEHAVIORAL HEALTH SERVICES REFERRAL

Medi-Cal

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

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

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

OneCare

To refer a OneCare member for routine or urgent behavioral health services, call CalOptima Behavioral Health at **855-877-3885** and choose the OneCare option**.** The member will be connected to a CalOptima representative to assist the member in obtaining appropriate services. The line is available 24 hours a day, seven days a week. TTY users can call **800-735-2929.**

HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES

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

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

CalOptima Policies and Procedures:

GG.1900: Behavioral Health Services

CMC.6033: Assessment, Referral, Coordination and Information Sharing for Cal MediConnect Members

GG.1548: Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder

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

This section applies to the following CalOptima programs:

Medi-Cal

D4: DENTAL SERVICES

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

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

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

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

MEDI-CAL DENTAL PROGRAM BENEFITS

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

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

HOW TO MAKE A DENTAL REFERRAL

1. To make a referral to the Denti-Cal program, call Denti-Cal at 800-322-6384, or go to the Denti-Cal website at: Denti-Cal. TDD/TTY users can call **800-735-2922**.
2. All children with an activ**e infection,** pain or severe problems should be referred to the Denti-Cal program for immediate diagnosis and treatment by a dentist or oral health surgeon. Children with other dental problems should be referred within a reasonable period of time for diagnosis and treatment.

3. All children over age three should be referred to a dentist. Children over age three should have the benefit of definitive dental diagnosis, remedial treatment and should be seen by a dentist at least annually.

CalOptima Policies and Procedures:

GG.1504: Dental Services

Section D: Services Covered by Other Agencies

This section applies to the following CalOptima programs:

Medi-Cal

D2: DRUG AND ALCOHOL ABUSE SERVICES

Alcohol and drug abuse services are a covered benefit for CalOptima Medi-Cal members, although these services are available through Drug Medi-Cal Organized Delivery System (DMC-ODS) administered by the Orange County Health Care Agency (OC HCA).

DMC-ODS provides substance use disorder (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.

ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care setting to members 18 and older who may misuse alcohol. Providers in primary care setting screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

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 the (AMSC), please visit the Providers section on CalOptima's website.

HOW TO MAKE A REFERRAL TO ALCOHOL AND DRUG ABUSE SERVICES

Both the member's primary care provider (PCP) and behavioral health provider can make referrals to alcohol and drug abuse services. To receive member information related to substance abuse or behavioral health services covered by CalOptima, contact CalOptima 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 hours a day, 7 days a week. For more information about the ODS plan, individuals can call OC HCA Members Services at 855-625-4657, Monday through Friday, between 8 a.m. and 6 p.m.

CalOptima Policies and Procedures:

GG.1100: Alcohol and Substance Abuse Treatment Services

This section applies to the following CalOptima 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 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 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, to 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 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 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's network and/or is located outside the county, CalOptima or one of its health networks will be responsible for coordinating and approving those services, as appropriate.

CCS services for non-CalOptima members will remain the responsibility of the local CCS program administered by the Orange County Health Care Agency (OC 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 Orange County Social Services Agency regarding Medi-Cal eligibility.

IDENTIFYING PATIENTS POTENTIALLY ELIGIBLE FOR CCS SERVICES

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

- Congenital heart disease
- Chronic renal disease
- Malignant neoplasms (including leukemia)
- Hemophilia and other coagulopathies
- Endocrine disorders (including diabetes)
- Organ transplant candidates
- Major trauma
- Serious chronic kidney problems
- Liver or intestine diseases
- Hearing loss, cataracts
- Rheumatoid arthritis, muscular dystrophy
- Severely crooked teeth
- Cancer, tumors
- Chronic lung disease
- 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 California Department of Health Care Services (DHCS) website by clicking here: CCS Eligibility, or the County of Orange website by clicking here: California Children's Services.

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

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

HELPFUL INFORMATION FOR AUTHORIZATION PROCESS

Requests for CalOptima Direct and CalOptima Community Network members for services requiring prior authorization should be submitted to CalOptima's Utilization Management department by facsimile or through the CalOptima 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 and its health networks.
- For questions regarding Medical Therapy Program (MTP), and all CCS services for non-Medi-Cal members, please contact the local CCS program administered by OC HCA at 714-347-0300.
- The Pediatric Palliative Care Waiver program ended on December 31, 2018. Beginning January 1, 2019, children enrolled in CalOptima receive palliative care services through CalOptima or their health network.

CONTINUITY OF CARE

CalOptima 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 existing relationship with the provider

- Provider accepts CalOptima's (or health network's) reimbursement rate or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless otherwise agreed; and
- 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 member who is CCS-eligible, you may request continuity of care on the member's behalf. Contact CalOptima Customer Service at **714-246-8500** for more information.

If the WCM member has an established relationship with a custom DME provider, CalOptima 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 provider for CCS, providers can submit a CCS panel application online to the link: Children's Medical Services.
- Providers may track their application status online with a unique tracking number. In addition, providers will receive an immediate online approval or request for any additional documentation necessary to process their pending applications.

Providers can find CCS program participation requirements by provider type at the DHCS webpage: https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Details about how to become a CCS-paneled provider are at the DHCS webpage: http://www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx

All CCS providers are encouraged to contact CalOptima and its delegated health networks about contracting. Please contact the CalOptima 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 CalOptima Direct or CalOptima Community Network), 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, both electronic and hard copy formats are accepted.

For questions regarding the submission of claims, contact CalOptima's Claims department at 714-246-8885.

Electronic claims submission: CalOptima 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 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

- In order 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's WCM program is available at:
https://www.caloptima.org/en/About/CurrentInitiatives/WholeChildModel.aspx
Or call 714-347-0300 (CalOptima providers only)

Health Network	Phone Number
AltaMed Medical Group	855-848-5252
AMVI Care Health Network	888-747-2684
Arta Western Health Network	310-354-4200
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
Kaiser Permanente	800-464-4000
Monarch Family HealthCare	888-656-7523
Noble Mid-Orange County	888-880-8811
Prospect Medical Group	800-708-3230
Talbert Medical Group	310-354-4200
United Care Medical Group	877-225-6784

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

This section applies to the following CalOptima programs:

Medi-Cal,

D6: HOME- AND COMMUNITY-BASED SERVICES REFERRALS

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

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

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

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

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

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

If you have a member who qualifies for home- and community-based services, please call the CalOptima Case Management department at **714-246-8686**.

This section applies to the following CalOptima programs:

Medi-Cal

D7: REGIONAL CENTER OF ORANGE COUNTY SERVICES

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

Who is Eligible to Participate in RCOC?

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

What Types of Services are Available Through the RCOC?

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

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

COORDINATION OF MEMBER CARE

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

HOW TO REFER A MEMBER TO THE RCOC

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

CalOptima Policies and Procedures:

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

Eligibility Verification and Enrollment

- Verifying Member Eligibility
- Medi-Cal Recipients Not Enrolled in CalOptima
- CalOptima's Medi-Cal and OneCare Member ID Card
- Medi-Cal Share of Cost Members
- Share of Cost for LTC Services

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

E1: VERIFYING MEMBER ELIGIBILITY

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

HOW TO VERIFY MEMBER ELIGIBILITY

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

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

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 or its health networks.

CalOptima Policies and Procedures:

DD.2003: Member Identification and Eligibility Verification

This section applies to the following CalOptima programs:

Medi-Cal

E2: MEDI-CAL RECIPIENTS NOT ENROLLED IN CALOPTIMA

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

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

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

- **Beneficiary Is Medi-Cal Eligible and Enrolled in CalOptima** — For these recipients the state systems will reference the beneficiary as "Medi-Cal Eligible" and indicate "Health Plan Member: CalOptima." The state system will also display "Health Care Plan: CalOptima" or the name of the member's CalOptima health network if the member is enrolled in a health network.
- **Beneficiary Is Medi-Cal Eligible but Not Enrolled in CalOptima** — For these recipients, the state systems will reference the beneficiary as: "Medi-Cal Eligible," but it will not include a "Health Plan Member" or "HCP" statement. This indicates that the beneficiary is not enrolled in CalOptima and remains in the Medi-Cal fee-for-service program. Providers should submit bills for Medi-Cal covered services furnished to these beneficiaries directly to the Medi-Cal fee-for-service program.
- **Beneficiary Is Not Medi-Cal Eligible** — If a person is not eligible for Medi-Cal benefits, the state systems will display the following message: "No Recorded Eligibility for (the date of service)."

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

For more information on how to bill the DHCS Medi-Cal fee-for-service program, please visit: www.dhcs.ca.gov/

This section applies to the following CalOptima programs:

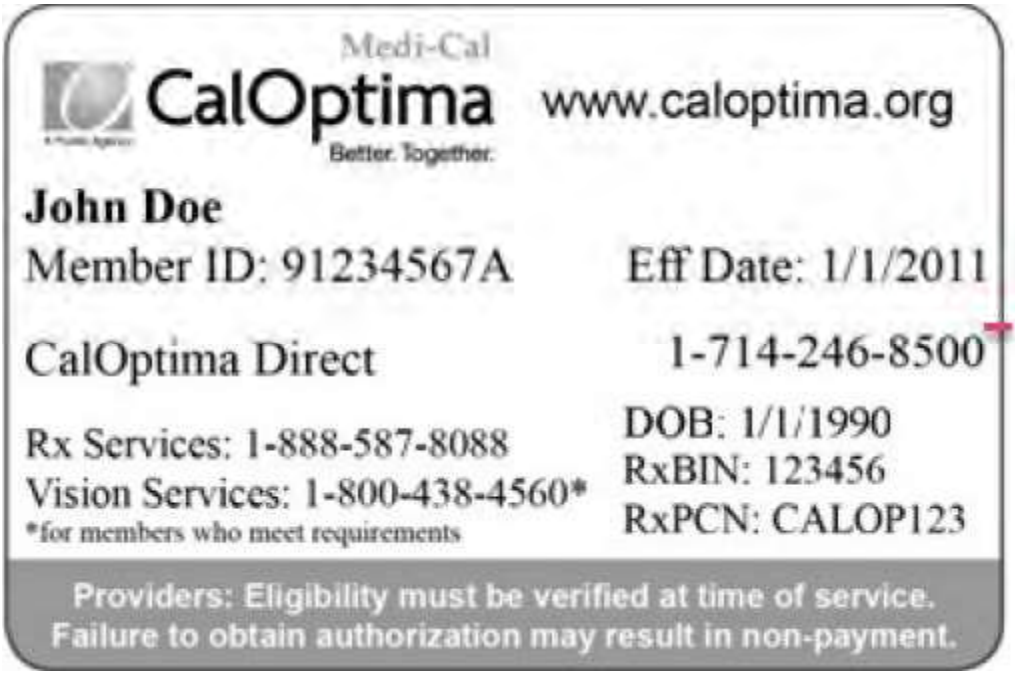
Medi-Cal, OneCare (HMO SNP),

E3: CALOPTIMA'S MEDI-CAL and ONECARE (HMO SNP) MEMBER ID CARD

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

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

Sample CalOptima Medi-Cal ID Card



Sample Medi-Cal BIC Card





IMPORTANT TIPS ABOUT THE MEMBER ID CARD

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

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

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

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

ONECARE MEMBER ID CARD

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

Sample CalOptima OneCare Member ID Card



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 health plan number
    d. Member's date of birth
    e. Member's effective date
    f. Member's primary care provider (PCP) name
    g. Phone number of member's PCP
    h. Member's health network
    i. Phone number of member's health network
    j. 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 Link located on CalOptima's website or by calling CalOptima's Interactive Voice Response (IVR) line at **714-246-8540** or **800-463-0935**. For more information on verifying a member's eligibility, see **Section E1: Verifying Member Eligibility**.

This section applies to the following CalOptima 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 members with a Medi-Cal share of cost must satisfy their monthly share of cost amount before they can access Medi-Cal covered benefits during the month(s) in which they satisfy their share of cost.

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

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

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

HOW TO DETERMINE AND CLEAR A MEMBER'S SHARE OF COST

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

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

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

1. By logging on to Medi-Cal website: www.medi-cal.ca.gov/
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 programs:

Medi-Cal

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

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

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

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

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

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

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

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

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

Providers should notify DHCS when payment is received from a Medi-Cal beneficiary as part of the member's share of cost. For further information regarding share of cost, refer to the DHCS LTC Medi-Cal Manual. CalOptima operates in accordance with established Medi-Cal guidelines.

Authorization and Referral Guidelines

- Wheelchair Authorization and Repair Requests
- Non-Emergent Medical Transportation (NEMT)
- Incontinence Supply Information

This section applies to the following CalOptima programs:

Medi-Cal

F8: WHEELCHAIR AUTHORIZATION AND REPAIR REQUESTS

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

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

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

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

HOW TO REQUEST AUTHORIZATION OF A STANDARD WHEELCHAIR

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

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

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

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

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

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

HOW TO REQUEST AUTHORIZATION OF A CUSTOM WHEELCHAIR

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

2. If a provider identifies a CalOptima Direct member in need of a custom wheelchair, the provider should complete a Customized Wheelchair Evaluation Request (CWER) form and Wheelchair Clinical Questionnaire. To obtain copies of these forms, please visit the Providers section of CalOptima's website.

3. When completing the CWER and Clinical Questionnaire, the provider must supply the following information:

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

4. If the request involves a health network member, the provider should submit the authorization request to the member's health network. For CalOptima Direct members, the provider should fax the CWER and Clinical Questionnaire to CalOptima's Care Coordination department at **714-481-6516**.

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

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

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

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

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

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

For more information, see the Custom Wheelchair Request and Approval Process Provider Fact Sheet by calling the CalOptima Prior Authorization department at **714-246-8686**.

HOW TO REQUEST AUTHORIZATION OF A WHEELCHAIR REPAIR

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

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

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

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

    a. Member's name, date of birth, phone number, address and Medi-Cal Client Identification Number (CIN)
    b. Full name, address, telephone number and signature of the prescribing provider
    c. Date of request
    d. Description of the repair or maintenance required

5. If the case involves a health network member, the provider should submit the authorization form to the member's health network. For CalOptima Direct members, the provider should fax the Wheelchair Repairs Authorization Request Form to CalOptima's Care Coordination department at **714-841-6516**.
6. CalOptima or the health network will review the request for benefit coverage, frequency limits and medical necessity. CalOptima or the health network will approve, modify or deny the request for wheelchair repair in accordance with CalOptima Policy GG. 1508: Authorization and Processing of Referrals.

CalOptima 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 programs:

Medi-Cal

F9: NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) REQUESTS

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

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

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

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

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

HOW TO REQUEST NON-EMERGENCY TRANSPORTATION SERVICES FOR A MEMBER

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

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

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

4. Please be sure to include the following on the Non-Emergency Medical Transportation (NEMT) Authorization Request:
   a. The purpose of the trip
   b. The frequency of the necessary medical transportation or inclusive dates of the requested medical transportation
   c. Medical or physical condition that makes normal public or private transportation inadvisable, with accompanying medical records to substantiate medical necessity
   d. Physician signature and date

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

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

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

CalOptima Policies and Procedures:

GG.1505: Transportation, Emergency & Non-Emergency

O

This section applies to the following CalOptima programs:

Medi-Cal

F11: INCONTINENCE SUPPLY INFORMATION

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

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

TIPS TO REQUEST INCONTINENCE SUPPLIES

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

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

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

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

CalOptima Policies and Procedures:

GG.1114: Authorization for Disposable Incontinence Supplies

Authorization Process for Long-Term Care (LTC)

- Authorization Process for LTC
- Initial Authorization: Skilled Nursing Facilities (SNF), Nursing Facility Level A (NF-A) and Level B (NF-B)
- Reauthorization-Regular: Skilled Nursing Facilities, Nursing Facility Level A (NF-A) and Level B (NF-B)
- Initial Authorization: ICF/DD, ICF/DD-H, ICF/DD-N
- Reauthorization: ICF/DD, ICF/DD-H, ICF/DD-N
- Initial Authorization: Subacute Adult and Pediatric
- Reauthorization: Subacute Adult and Pediatric
- Retroactive Eligibility: Authorization and Process Guidelines
- Bed Hold and Leave of Absence: Authorization Requests
- Deferred LTC Authorization Request Forms (ARF)
- Discharge Notification
- Nursing Facility (NF) A- Level of Care Criteria
- Criteria for Admission and Continued Stay- SNF
- LTC ARF Process and Criteria: NF-A and Level B NF-B

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

G1: AUTHORIZATION PROCESS FOR LONG-TERM CARE

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

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

- Nursing Facility Level A (NF-A) and Level B (NF-B) (formerly "custodial" care)
- 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 Utilization Management:

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

It is important to note that under CalOptima:

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

LONG-TERM SERVICES AND SUPPORTS CONTACT INFORMATION

Long-Term Services and Supports Contact Information	Phone Numbers and Website Addresses
CalOptima Long-Term Services and Supports (LTSS) Information	General: **714-246-8444** or **800-965-8979** Fax Number: **714-246-8843** Website: www.caloptima.org/
CalOptima Long-Term Services and Supports Mailing Address	CalOptima 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 MD Electronic Preadmission Screening and Resident Review (PASRR) DHCS 6170 form 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 MD 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 Minimum Data Set (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 MD 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 MD Electronic PASRR (DHCS 6170 form) Minimum Data Set (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

Description	Forms/Resources	Timing Requirements	Reference in Manual
Does Not Require Authorization, (but does require notification)		Nursing Facility (NF) notifies LTSS within 24 hours of start date of services, or the next business day by telephone or facsimile. Does not require prior authorization.	LTC Treatment in Place Notification Form 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. 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 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. The only discharge it is "required" for is "community discharges".	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 programs:

Medi-Cal, OneCare (HMO SNP),

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

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

- The CalOptima member is a new admission to the facility.
- The CalOptima 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 member while residing in the facility. This can be either:
    a. A new Medi-Cal beneficiary
    b. An existing Medi-Cal beneficiary whose county of eligibility has changed from another county to Orange County (CalOptima). Please review the section of this manual pertaining to member eligibility for more specific eligibility guidelines.
- When the CalOptima health plan is no longer responsible for a short stay.

Process to Obtain a CalOptima LTC Authorization

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

LTC Authorization Request Form Process:

For Nursing Facility that requires NCM on-site visit

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 present to CalOptima LTC NCM during the scheduled on-site visit.

For Fax-in 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, 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 LTC ARF must be presented with the following documentation for adjudication:

- A complete and accurate electronic Preadmission Screening Resident Review (PASRR) DHCS 6170 form on or before the day of member's admission to the facility
- 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 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. 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 LTC-NCM will review the initial LTC ARF during the regularly scheduled facility on-site visit or via a fax-in ARF review process when the NF is a "fax-in" building and makes determination to approve, deny or modify per Department of Health Care Services (DHCS) standard clinical criteria for long-term care services and CalOptima LTSS policy.

If the initial LTC ARF is approved, CalOptima 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 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

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

- When a member who is residing in an LTC NF becomes acutely ill, the LTC primary care provider (PCP) or physician designee may determine if the member can be safely treated at the NF, write the order for TIP and specify the estimated length of stay.
- The SNF shall:
    a) Complete the LTC Treatment in Place Notification Form
    b) Identify the length of stay (start and end date)
    c) Indicate the level of skilled nursing care as SN2:
    d) Level II, skilled medical and rehabilitation care, revenue code 192
    e) NFs will be paid for treatment in place services based on their specific contracts.
    f) Fax completed LTC Treatment in Place Notification Form (signed by the LTC PCP or nurse practitioner) to CalOptima Long-Term Services and Support (LTSS) at **714-246-8843**.
- CalOptima LTSS department staff shall review the circumstances resulting in the treatment in place being initiated, and complete "Pay and Educate" if the NF has made any errors. Prior authorization for treatment in place services is not required. CalOptima LTSS department will not require any authorization for treatment in place services but does require notification within 24 hours of initiation of TIP services.
- When an extension for TIP is needed, the SNF shall submit a new LTC TIP Notification Form with dates of service and "extension" clearly written on the form. This TIP Notification form shall be submitted to CalOptima's LTSS department within 24 hours of the extension being initiated.
- SNF staff shall monitor treatment in place throughout the member's length of stay and notify CalOptima LTSS department of the following:
    a) If the member has returned to the previous level of care or
    b) If the member has not returned to the previous level of care and needs an extension for treatment in place.

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

CalOptima Policies and Procedures:

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

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

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 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 MD signing the ARF) and documentation to support the level of care requested, and present to the CalOptima on-site nurse.

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

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

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

CalOptima Policies and Procedures:

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

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

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

GG.1807 Authorization Review Process, Long-Term Care

This section applies to the following CalOptima 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 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 LTSS department shall document the authorization as requested in the medical management system and provide an authorization number to the admitting facility.
- CalOptima's LTSS department will enter a reauthorization into the medical management system when an ICF/DD, ICF/DD-H, ICF/DD-N sends the Regional Center the signed HS 231 form with reauthorization information to CalOptima.
- Upon notification by the facility of a member's discharge, CalOptima LTSS shall close the active LTC authorization effective the day of discharge. The facility shall notify CalOptima within three business days of a member's discharge by submitting the Discharge Disposition Form.
- CalOptima shall ensure continuity of care for members residing in an ICF/DD, ICF/DD-H, ICF/DD-N in accordance with CalOptima Policy GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima.
- 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 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 Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

Process for obtaining a CalOptima LTC Authorization:

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

- **Authorization:** Fax the following documents to CalOptima:
  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 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 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 programs:

Medi-Cal

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

TIMELINESS REQUIREMENTS FOR REAUTHORIZATION REQUESTS

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

PROCESS FOR OBTAINING A REAUTHORIZATION

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

- **Authorization:** Fax the following documents to CalOptima 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 LTSS shall request the facility resubmit completed required documentation.

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

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

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

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

CalOptima Policies and Procedures:

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

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

G6: INITIAL AUTHORIZATION — SUBACUTE/ADULT AND PEDIATRIC

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

- The CalOptima member is a new admission to the nursing facility (NF).
- The CalOptima 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 8).
- The member returns from an approved leave of absence beyond the approved time period allowed.
- The resident has become a CalOptima member while residing in your facility. This can be either:
    a. A new Medi-Cal beneficiary
    b. An existing Medi-Cal beneficiary whose county of eligibility has changed from another county to Orange County (CalOptima). Please review the section of this manual pertaining to member eligibility for more specific eligibility guidelines.

PROCESS FOR OBTAINING A CALOPTIMA LTC AUTHORIZATION

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

- **Authorization:** Complete section I, II, III, IV and V of the LTC ARF, including physician signature (may provide a signed MD order for admission in lieu of MD signature on ARF) and documentation to support the level of care requested, and present to CalOptima.

- **The CalOptima LTC ARF** must be presented with the following documentation for adjudication:
    a. A copy of the complete and accurate electronic Preadmission Screening (PASRR) DHCS 6170 form completed on or before the day of member's admission to the facility
    b. Medicare, facility or other insurance denial, if appropriate
    c. Minimum Data Set (MDS) if available, and sufficient chart documentation to support the medical necessity for the level of care requested
    d. Completed DHCS 6200-A/DHCS 6200 form proof (via time stamp) that the member's name and admission date was entered on the 21-Day List (before the end of 21 days in the NF) and faxed to CalOptima LTSS department as notification of the admission. If the member's name and admission date were not placed on the 21-Day List as required but meets level of care criteria, a 15% 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 LTC Program.

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

Medi-Cal, OneCare (HMO SNP),

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 eligibility. Refer to the eligibility section of this manual for specific eligibility guidelines.

- **Authorization:** Complete and present the following documents to CalOptima on-site nurse prior to the expiration of the current authorization:
    a. Sections I, III, IV of the LTC ARF, including a physician signature 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 on-site nurse will adjudicate the LTC ARF during the scheduled facility visit. If the LTC ARF is approved, CalOptima will fax a copy of the approval letter to the facility and an LTC ARF reference number will be given at that time.

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

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

CalOptima Policies and Procedures:

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

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

GG.1807 Authorization Review Process, Long-Term Care

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

G8: RETROACTIVE ELIGIBILITY: AUTHORIZATION AND PROCESS GUIDELINES

DETERMINING RETROACTIVE ELIGIBILITY:

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

- Long-Term Care Authorization Request Forms (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 LTC Authorization as outlined in Policy and Procedure GG.1809 Retroactive Authorization Request for Long-Term Care Facility.

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

- 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 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 document is required as applicable:
        - Notice of Action (NOA)
        - Integrated Denial Notice (IDN)
        - Notice of Medicare Non-Coverage (NOMNC)
        - Other Health Care (OHC) Explanation of Benefit
    b. Electronic Preadmission Screening Resident Review (PASRR) Level I Screening Document (initial requests only) (ICF/DD, ICF/DD-H, and ICF/DD-N facilities are exempt)
    c. Most recent Minimum Data Set (MDS), either full assessment for admission or the latest quarterly assessment for continued stay
    d. Nurse's notes, Social Services Agency (SSA) evaluations or physician orders if the MDS does not reflect the need for skilled care placement (ICF/DD, ICF/DD-H, and ICF/DD-N facilities are exempt)
    e. Signed certification of Special Treatment Program Services Form HS 231 for ICF/DD, ICF/DD-H and ICF/DD-N facilities only
    f. 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 member or member's authorized representative to transfer benefits to the facility's county if appropriate (i.e., member will remain a resident long-term or member does not have an Orange County Public Guardian).

CalOptima Policies and Procedures:

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

FF.1806: Preadmission Resident Review Screening (PASRR)

GG.1809 Retroactive Authorization Request for Long Term Care Facility.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

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 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 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 greater than seven days of general acute care hospitalization, the facility is not required to hold the bed and shall not bill CalOptima for any remaining bed hold days.
- 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 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: 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 8.	LTC ARF Completion Instructions

GENERAL RULES FOR LEAVE OF ABSENCE:

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

- 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 LTC AUTHORIZATION FOR BED HOLD

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

- Bed Hold (BH) LTC ARF is required for CalOptima 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 LTSS department.

- CalOptima members admitted for skilled short stay services require BH authorization requests when skilled services are being authorize by Medicare, CalOptima 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 members with approved LTC authorization services.

- LTC nursing facility may submit BH payment request to CalOptima 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 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 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 will fax a copy of the approval letter to the facility and an LTC ARF reference number will be given at that time.

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

CalOptima Policies and Procedures:

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

GG. 1810: Bed Hold, Long-Term Care

GG.1811: Leave of Absence, Long-Term Care

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

O

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 on the 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 member, LTC nursing 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/member 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. Examples, 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 re-schedule an on-site visit or can review the deferred LTC ARF as a faxed-in request within the 14 calendar days of Delay Letter and before the 28th day.

- The NCM will send activity to CalOptima Medical Director for all **medical necessity reviews** when unable to make a determination due to level of care criteria are not met, or there is insufficient documentation of medical necessity. CalOptima 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 members and providers.

- CalOptima shall send a Notice of Action (NOA) letter to the provider and CalOptima 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 member would then have the right to request an appeal with CalOptima within the appeal time frame as stated in the NOA letter.

CalOptima Policy and Procedure:

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

GG.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 programs:

Medi-Cal, OneCare (HMO SNP),

G11: DISCHARGE NOTIFICATION

DISCHARGE DISPOSITION FORM REQUIREMENT:

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

DISCHARGE NOTIFICATION IS REQUIRED WHEN:

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

NOTIFICATION PROCESS:

- 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 member residing in their facilities and send form (MC 171) to appropriate agency.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

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 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 programs:

Medi-Cal, OneCare (HMO SNP),

G13: CRITERIA FOR ADMISSION AND CONTINUED STAY — SKILLED NURSING FACILITY (SNF)

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

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

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

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

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

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

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

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

CONTINUING CARE DETERMINATIONS

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

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

Medical functional factors of the patient must support a sound professional judgment that a prolonged period of care will be required. The following medical/functional factors shall be used to reach the decision on prolonged care status:

1. Highest indications of need for prolonged care:
    a. Total or severe incontinence, which despite bowel and bladder training, has failed to improve
    b. Bedridden and/or comatose or semi-comatose states
    c. Conditions which have resulted in quadriplegia, hemiplegia, spasticity, rigidity, and uncontrolled movements, tremors or deformity dependent upon severity or intensity

d. Conditions which require a high degree of prolonged medical nursing support and supervision (depending upon the patient's ability to participate responsibly in his/her own care). These include complex regimens of oral and/or parenteral medications and diet to control diabetes, cardiac conditions, seizure disorders, hypertension, tumor conditions, obstructive pulmonary conditions, infectious conditions and pain.
e. Conditions that require a high degree of prolonged mechanical nursing support and supervision (depending upon the patient's ability to participate responsibly in the patient's own care). These include tracheotomies, gastrostomies, colostomies, catheters, N/G tubes, IPPB machines, irrigation procedures, medicinal installation procedures, dressing changes, and conditions requiring sterile technique.
f. Conditions requiring medical/psychiatric/developmental nursing support and supervision (dependent upon severity and the patient's ability to participate responsibly in his/her own care). These include extreme confusion and disorientation, inability to communicate, unacceptable physical, sexual or verbally aggressive behavior and anxiety or depression which is secondary to the medical/physical condition (e.g., terminal cancer).

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

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

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:
    a. A tracheostomy with continuous mechanical ventilation for at least 50 percent of the day
    b. Tracheostomy care with suctioning and room air mist or oxygen as needed and one of the six treatment procedures listed in Section F
    c. Administration of any three of the six treatment procedures listed in Section F

F. Treatment Procedures
    1. Total parenteral nutrition (TPN)
    2. Inpatient physical, occupational and/or speech therapy at least two hours per day, five days per week
    3. Tube feeding (NG or gastrostomy)
    4. Inhalation therapy treatments during every shift and a minimum of four times per 24-hour period
    5. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or frequent IV drug administration via a peripheral and/or central line without continuous infusion such as via heparin lock
    6. Debridement, packing and medicated irrigation with or without whirlpool treatment

This section applies to the following CalOptima programs:

OneCare (HMO SNP),

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

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.

CalOptima 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

Claims and Billing Guidelines

- Other Health Coverage
- Member Billing Restrictions

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

H9: OTHER HEALTH COVERAGE

When a member has other health coverage, CalOptima is the payer of last resort. Providers should coordinate benefits for covered services with other programs or entitlements recognizing other health coverage as primary coverage.

Providers should bill the other health coverage (OHC) carrier prior to billing CalOptima. The OHC carrier may reimburse at a higher rate than CalOptima. If a provider receives a partial payment from the OHC carrier, CalOptima may be billed for the balance for benefit/payment consideration as the payer of last resort. The provider must attach a copy of the complete Explanation of Benefits (EOB) from the primary carrier, including descriptions of denied charges.

CalOptima's reimbursement is the difference between the CalOptima allowable amount and the other health coverage carrier payment.

IMPORTANT REMINDERS REGARDING OHC

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

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

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

   Please call DHCS at 800-952-5294 between 8 a.m. and 5 p.m. to report possible other health coverage, or write to:

   Department of Health Care Services Health Insurance Section
   P.O. Box 1287
   Sacramento, CA 95812-1287

   Please indicate recipient's name, Social Security number and name of the other health coverage insurance plan.

3. **Nondiscrimination of CalOptima Beneficiaries**
   Under state law, when a provider obtains proof of eligibility, the provider must accept the CalOptima recipient and be bound by the rules and regulations of the CalOptima program. If a provider obtains proof of eligibility that indicates a recipient is eligible to receive services, the provider cannot treat the recipient as private pay because of the recipient's OHC status. However, if the provider cannot be paid by the recipient's OHC because the provider does not participate in the recipient's OHC plan, the

provider should refer the recipient to the OHC for treatment. CalOptima is not liable for OHC covered services if the recipient elects to seek treatment from a provider not authorized by the OHC.

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

5. **When to Bill Other Health Coverage**
When requesting eligibility verification for a recipient with OHC, the CalOptima eligibility verification system returns a message stating a recipient's scope of coverage. If a recipient's OHC code is one of the following and the service rendered falls within the recipient's scope of coverage, the provider must refer the recipient to the health maintenance organization (HMO) or bill the OHC indicated on the eligibility verification message, before billing CalOptima.

OTHER HEALTH COVERAGE (OHC) CODES CHART

OCH 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
I	MetraHealth
J	John Hancock Mutual Life Insurance
K	Kaiser (HMO)

OCH Code	Carrier
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
3	Principal Financial Group/ Principal Mutual
4	Pacific Mutual Life Insurance
5	First Health/Alta Health

OCH Code	Carrier
6	American Association of Retired Persons (AARP)
7	Undefined
8	New York Life Insurance
9	Healthy Families (HF) Program

Unless a provider is an authorized provider of a recipient's health plan, refer recipients with HMO coverage to the plan for covered treatment, or contact the HMO for a treatment authorization. CalOptima is not liable for the cost of HMO-covered services if the recipient elects to seek treatment from a provider not authorized by the HMO. To establish CalOptima's liability, the provider must obtain an acceptable denial letter from the HMO.

6. **Scope of Coverage Codes**
The CalOptima eligibility verification system returns the scope of coverage code when coverage information is available to the DHCS. Up to seven codes may be returned. Scope of coverage codes designate the specific service categories covered by the recipient's health coverage.

SCOPE OF COVERAGE CODES CHART

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
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 eligibility verification system. This message indicates presumed coverage for all claim types except long-term care and dental. Providers must bill the insurance carrier for all other services before billing CalOptima.

If a recipient has reported multiple insurance policies, the eligibility verification system identifies the name of the other health coverage insurance carrier(s), or the carrier codes if the Automated Eligibility Verification System (AEVS) is accessed.

7. Billing CalOptima After Other Health Coverage

These principles must be followed when billing CalOptima after other health coverage:

a. The other health coverage benefit must be used completely.
b. CalOptima may be billed for the balance, including other health coverage co-payments, other health coverage coinsurance and other health coverage deductibles.
c. CalOptima will pay up to the limitations of the CalOptima program, less the other health coverage payment amount, if any.
d. CalOptima will not pay the balance of a provider's bill when the provider has an agreement with the other health coverage carrier/plan to accept the carrier's contracted rate as a "payment in full."
e. An Explanation of Benefits (EOB) or denial letter from the other health coverage must accompany the CalOptima claim, except for pharmacy providers.
f. The amount, if any, paid by the other health coverage carrier for all items listed on the CalOptima claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any other health coverage payment.

8. Other Health Coverage EOB or Denial Letter

a. When billing CalOptima for any service partially paid or denied by the recipient's other health coverage, the other health coverage EOB or denial letter must accompany the claim.
b. When a service or procedure is not a covered benefit of the recipient's other health coverage, a copy of the original denial letter or EOB is acceptable for the same recipient and service for a period of one year from the date of the original EOB or denial letter.
c. A dated statement of non-covered benefits from the carrier is also acceptable if it matches the insurance name and address and the recipient's name and address and clearly states the benefits not covered.
d. It is the provider's responsibility to obtain a new EOB or denial letter at the end of the one-year period. Claims not accompanied by proper documentation will be denied.

9. Medicare Coverage

a. Other health coverage code F —Identifies CalOptima recipients who receive benefits from:
    i. Medicare HMO
    ii. Medicare-contracted HMO in lieu of Medicare fee-for-service

Recipients who have CalOptima and Medicare HMO coverage must seek medical treatment through their Medicare HMO. CalOptima is not liable for payment for HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO. CalOptima claims for recipients with Medicare HMO coverage are not Medicare/CalOptima crossover claims. Therefore, to bill CalOptima for services not included in the Medicare HMO plan, submit a CalOptima claim accompanied by an Explanation of Benefits (EOB) or denial letter showing either that the Medicare HMO was billed first and partial payment was made or that the Medicare HMO does not cover the service. Most claims for

Medicare/CalOptima Direct recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits.

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

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

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

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

Straight CalOptima claims must be billed directly to CalOptima if any of the following apply:

- The services are not covered by Medicare.
- Medicare benefits have been exhausted.
- Medicare has denied the claim.
- The recipient is not eligible for Medicare.

These are not crossover claims. For billing and timeliness instructions, refer to the UB-04 and CMS 1500 Completion and CMS 1500/UB04 Submission and Timeliness Guidelines.

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

   All services or supplies on a straight CalOptima Direct claim must be included in the Medicare Non-Covered Services charts for direct billing. If a service or supply is not included in the chart, submit the corresponding Medicare Explanation of Medicare Benefits (EOMB) showing the services or supplies that are not allowed by Medicare when billing CalOptima Direct.

2. **Medicare Exhausted Services**
   Physical therapy and occupational therapy for CalOptima Direct patients with Medicare coverage must be billed to the appropriate Medicare carrier or intermediary. After Medicare benefits for physical and occupational therapy have been exhausted, providers may bill CalOptima directly and must include a copy of the Medicare EOMB that shows the benefits are exhausted.

3. **After Medicare Benefits Have Been Exhausted**
   These claims must be billed directly to CalOptima Direct on a CMS 1500, including a copy of the Medicare EOMB, showing the benefits that are exhausted.

4. **Medicare Denied Services**
   Medicare denied services should be billed as straight CalOptima Direct claims. To bill for Medicare denied services, follow these steps:

a. Submit an original CMS 1500 (08/05 version only).
b. Complete the claim according to instructions in the CMS 1500 completion instructions.
c. Do not include any Medicare approved services on the claim. The Medicare approved services must be billed separately as a crossover claim, unless contract specifies Medicare rates.
d. Attach a copy of the Medicare EOMB indicating the denial.
e. If the Medicare denial description is not printed on the front of the Medicare EOMB, include a copy of the description from the back of the EOMB or the Medicare manual.
f. Attach a copy of any other health coverage EOB or denial letter if the recipient has cost-avoided other health coverage through any private insurance (refer to the Other Health Coverage Guidelines for Billing section in the DHCS Medi-Cal manual, Part 1). Providers can access a copy of the other health coverage on the CalOptima website at www.caloptima.org/.
g. Do not send these claims to the Crossover Unit.

5. **Services Denied When Included in Surgical Fee or Not Separately Payable**
CalOptima Direct does not pay for an office visit when Medicare has denied payment because the visit was included in the surgical fee. The surgical fee covers reimbursement of office visits on the same day that surgery is performed and during the follow-up period of the surgical procedure. In addition, CalOptima Direct does not pay for services denied by Medicare because the procedure is a component part of a group of services. CalOptima Direct will deny these claims with RAD code 027: "Services denied by Medicare (included in surgical fee, incidental, or not separately payable) are not payable by CalOptima Direct."

BILLING TIPS FOR MEDICARE NON-COVERED, EXHAUSTED OR DENIED SERVICES

The following billing tips will help prevent rejections, delays, incorrect payments and/or denials of claims for Medicare non-covered, exhausted or denied services:

1. A single claim form cannot be used when billing for the combination of Medicare-approved or covered services and Medicare non-covered, exhausted or denied services appearing on the same EOMB.

2. Medicare-approved/covered services must be billed as crossover claims according to the instructions in "Hard Copy Submission Requirements of Medicare Approved Services" in this section.

3. Medicare non-covered, exhausted or denied services must be billed to CalOptima Direct. Use the CMS 1500 and attach a copy of the Medicare EOMB for the exhausted or denied services.

4. If a Medicare denial description(s) is not printed on the front of an EOMB that shows a Medicare denied service(s), provider must copy the Medicare denial description(s) from the back of the original EOMB or from the Medicare manual and submit it to CalOptima Direct along with the bill for the Medicare denied service(s). This applies to any service(s) denied by Medicare for any reason.

5. When billing Medicare non-covered, exhausted or denied services for a recipient who has other health coverage through any private insurance, the provider must also bill the other health coverage before billing CalOptima Direct.

BILLING TIPS FOR MEMBERS WITH MEDICARE AND OTHER HEALTH COVERAGE AS PRIMARY INSURANCE

When a recipient has both Medicare fee-for-service and cost-avoided other health coverage, they must bill in the following order:

1. **First**: Bill Medicare for the Medicare-covered services (do not bill as an automatic crossover claim).

2. **Second**: Bill the other health coverage carrier.

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

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

CalOptima Policies and Procedures:
MA.3103: Claims Coordination of Benefits

This section applies to the following CalOptima programs:

Medi-Cal

H14: MEMBER BILLING RESTRICTIONS

The Department of Health Care Services (DHCS) and CalOptima have specific guidelines restricting the billing of CalOptima members by providers. This section describes the general prohibition on billing members for covered services, as well as the restrictions governing when a provider may bill a member.

BILLING MEMBERS FOR COVERED SERVICES IS PROHIBITED

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

- 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, 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, and
- A copy of the written agreement is provided to the member and placed in his or her medical record, or
- The rendering provider is not registered with Medi-Cal.

FACTS ABOUT THE MEMBER BILLING RESTRICTIONS

- Providers should always verify a CalOptima member's eligibility prior to rendering covered services and, if applicable, obtain appropriate prior authorization in accordance with CalOptima Policies and Procedures.
- With the exception of required co-payments or Medi-Cal share of cost, a participating provider should not bill, seek reimbursement or attempt to collect payment from a CalOptima member or the member's representative for covered services.
- With the exception of required co-payments or Medi-Cal share of cost, a non-participating provider should not bill, seek reimbursement or attempt to collect payment from a CalOptima member or the member's representative for authorized, urgent or emergent covered services.

- Providers should not collect payment (check, cash or credit card) for services rendered in lieu of billing a claim to CalOptima, its health network, medical group or third-party administrator.
- Providers should not bill a member for a claim that has been denied due to lack of authorization or due to untimely filing. Providers are solely responsible for seeking authorization of services and for submitting claims timely.
- Providers should never ask a CalOptima member to inquire about the status of a claim. The provider's staff cannot involve the member in any of the steps to collect payment from CalOptima.

CalOptima Policies and Procedures:

AA.1220: Member Billing

Pharmacy and Prescriber Information

- Formulary Information
- Pharmacy Prior Authorizations
- Monthly Medication Limit
- Medication Therapy Management Program
- Medication Use and Treatment Guidelines
- Pharmacy Network

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

I1: FORMULARY INFORMATION

CalOptima maintains an Approved Drug List (also referred to as a "Formulary") for the Medi-Cal plan, which lists medications available to CalOptima members without the need for prior authorization. CalOptima also maintains formularies for OneCare that list prior authorization requirements, quantity limits and step therapy edits.

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

HOW TO ACCESS THE FORMULARY

You can access the CalOptima formularies on our website at www.caloptima.org/.

You may also access the CalOptima formularies by using Epocrates,® which provides free mobile and online access to national and regional health care insurance formularies, including all Medicare Part D formularies. For more information about accessing the Approved Drug List using Epocrates,® please visit their website at www.epocrates.com/.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

I2: PHARMACY PRIOR AUTHORIZATIONS

In some instances, CalOptima's formularies may not include specific medications that a physician may want to prescribe for a member. A physician can submit a prior authorization or exception request for a medication that is not listed on the formulary or that does not meet a step therapy or contingent therapy restriction, quantity limit or duration-of-therapy limit listed on the formulary.

With very few exceptions, all medically necessary FDA-approved drugs are potentially covered under the CalOptima Medi-Cal pharmacy benefit. CalOptima may cover those drugs not listed on the formulary with an approved prior authorization.

HOW TO REQUEST PRIOR AUTHORIZATION

Complete a pharmacy prior authorization request form and fax the completed form to **858-357-2557**. For more information on this process and a copy of the form, please visit CalOptima's website at www.caloptima.org/.

1. You may request a pharmacy prior authorization by phone by calling **CalOptima's pharmacy benefit manager** at **888-807-5705** and following the automated instructions.

2. You may request a pharmacy prior authorization online using the Web Submission Form located on CalOptima's website at www.caloptima.org/.

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

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

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

This section applies to the following CalOptima programs:

Medi-Cal

I3: MONTHLY MEDICATION LIMIT

CalOptima maintains a monthly prescription limit of six medications per member per calendar month to minimize the risk of polypharmacy, the excessive and potentially dangerous use of prescription drugs and over-the-counter medications. Polypharmacy increases the risk of adverse drug reactions and drug-to-drug interactions.

CalOptima recognizes that some of your patients have unique medication needs. As a result, physicians may prescribe medications in excess of this limit with prior approval from CalOptima. CalOptima will approve requests to exceed this monthly limit if medically necessary. Please note that medications found on the Maintenance Drug List may be dispensed for up to a 60-day or 100-day supply (see individual medications listed). The Maintenance Drug List is posted on CalOptima's website.

CalOptima has standing exemptions for members with certain conditions or medical needs, including members with HIV/AIDS, transplant patients, cancer patients, patients who reside in nursing or subacute care facilities, and other individuals (on a case-by-case basis).

HOW TO REQUEST AN EXEMPTION TO THE LIMIT

To request an exemption from CalOptima's monthly medication limit on behalf of a member, complete the Request for Member Exemption from the Monthly Medication Limit form. For more information on the exemption limits and the form, please refer to CalOptima's website at www.caloptima.org/.

- Once you have completed the form, fax it to CalOptima at **714-481-6404**.
  Alternatively, you may also request an exemption by sending a letter to:

  CalOptima Pharmacy Management
  Attn: Polypharmacy Medication Review
  505 City Parkway West
  Orange, CA 92868

This section applies to the following CalOptima programs:

OneCare (HMO SNP),

I4: MEDICATION THERAPY MANAGEMENT PROGRAM

The OneCare Medication Therapy Management (MTM) program is a requirement under Medicare Part D and was developed with input from practicing pharmacists and physicians. Through a comprehensive review of a member's drug regimen, the primary goal of the Medication Therapy Management program is to identify, resolve and prevent medication-related problems to achieve optimal outcomes of drug therapy.

On a quarterly basis, CalOptima will identify certain members for participation in the program who will receive medication education materials. Members will be invited to participate in the program if they:

- Receive medications for three or more of the following diseases: diabetes, asthma, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia or end-stage renal disease (ESRD)
- Receive more than eight medications per quarter
  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 beneficiaries who are at risk of adverse events due to opioid overutilization who do not otherwise qualify for MTM.

MTM services are now being offered to members who meet expanded internal criteria based on the Part D Drug Management Program for potentially at-risk and at-risk beneficiaries. Identified members receive the same CMRs, TMRs and interventions that members who meet the specified MTM criteria receive. Members are identified for the Drug Management Program quarterly utilizing the following criteria for calendar year 2020:

- A look-back period of the previous six months
- Member prescription exceeded an average daily morphine milligram equivalent (MME) of 90 milligrams (mg) for any duration
  a. Filled opioid prescriptions written by three or more prescribers and at three or more pharmacies; or
  b. Filled opioid prescriptions written by five or more prescribers, regardless of the number of dispensing pharmacies
- Members excluded from the Drug Management Program include:
  a. Members being treated for active cancer-related pain
  b. Members receiving hospice, palliative or end-of-life care
  c. Members residing in certain facilities.

HOW TO FIND OUT MORE ABOUT ONECARE'S MTM PROGRAM

The member's primary care provider (PCP) plays an important role in the provision and coordination of quality care to OneCare members. Providers whose patients qualify for the Medication Therapy Management program will be notified to ensure coordination of the Medication Therapy Management program with respect to care given by the provider.

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

This section applies to the following CalOptima programs:

Medi-Cal

I5: MEDICATION USE AND TREATMENT GUIDELINES

To assist its providers most effectively with medications used to manage certain chronic conditions, CalOptima developed medication use guidelines for selected common conditions and for specific injectable drugs. These guidelines provide recommendations on appropriate drug therapy based upon specified clinical indicators, and also provide formulary information and prior authorization criteria. The guidelines were developed in conjunction with physician specialists. For more information on these guidelines, please visit the CalOptima website at www.caloptima.org/.

Clinical Guidelines

- Adult asthma
- Chronic obstructive pulmonary disease (COPD)
- Diabetes mellitus
- Hyperlipidemia
- Hypertension
- Major depression in adults

Injectable Drug Guidelines

- Somatropin (Serostim)

HOW TO ACCESS THE MEDICATION GUIDELINES

For more information on the medication guidelines, please visit CalOptima's website at www.caloptima.org/.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

I6: PHARMACY NETWORK

CalOptima's pharmacy network includes more than 500 pharmacies in Orange County and surrounding areas. CalOptima maintains a printed directory of network pharmacies, as well as a listing of network pharmacies on its website. Each network pharmacy serves all CalOptima programs — Medi-Cal, OneCare (HMO SNP)

HOW TO LOCATE A CALOPTIMA NETWORK PHARMACY

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

The website contains three network listings — a list that includes all network pharmacies, a listing of pharmacies providing specialty injectables and a listing of home infusion pharmacies.

Case Management

- Complex Case Management
- Case Management of Children with Special Health Care Needs
- End Stage Renal Disease (ESRD) Case Management
- Hemophilia Case Management
- Transplant Case Management
- Referring Members for Case Management
- Model of Care

This section applies to the following CalOptima programs:

Medi-Cal

J1: COMPLEX CASE MANAGEMENT

Case management is the coordination of care and services for members who have experienced a critical event or diagnosis or are high-risk members. Typically, these members require extensive use of resources and need help navigating the health care system to facilitate the appropriate delivery of care and services. The goal of CalOptima's Case Management program is to help members regain health or functional capability.

Who Qualifies for Case Management? Case management is provided to eligible members with specific diagnoses or special health care needs. This includes members with complex, acute and chronic diagnoses, or specialty care management needs. These members typically require extensive use of resources and need assistance in navigating the health care delivery system.

How Does Case Management Benefit Members? Case management provides a consistent method for identifying, addressing and documenting the health care and social needs of our members along the continuum of care. Once a member has been identified for case management, a nurse will work with the member to:

1. Complete a comprehensive initial assessment.
2. Determine benefits and resources available to the member.
3. Develop and implement an individualized care plan in partnership with the member, his or her provider, and family or caregiver.
4. Identify barriers to care.
5. Monitor and follow up on progress toward care plan goals.

HOW TO MAKE A REFERRAL TO CASE MANAGEMENT

1. **CalOptima Direct (COD) and CalOptima Community Network (CCN) Members:** If a provider identifies a CalOptima member needing case management, the provider can make a direct referral to CalOptima's Case Management department by calling **714-246-8686**, faxing **714-571-2455** or emailing cmtriage@caloptima.org.
2. **CalOptima Members Assigned to a CalOptima Health Maintenance Organization (HMO), Physician Hospital Consortium (PHC) or Shared Risk Medical Group Health Network:** If a provider identifies an HMO, PHC or Shared Risk Medical Group member needing case management, the provider can make a direct referral by contacting the member's assigned health network. For health network contact information, see **Section B1: CalOptima Department and Program Contact Information**.

If a provider has questions about CalOptima's Case Management program, call CalOptima's Case Management department at **714-246-8686**.

CalOptima Policies and Procedures:

GG.1301: Case Management Process

This section applies to the following CalOptima programs:

Medi-Cal

J2: CASE MANAGEMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

CalOptima is required to implement and maintain services for children with special health care needs. These services include, but are not limited to:

1. Ensuring and monitoring timely access to services
2. Providing a comprehensive assessment of the health and related needs of children with special health care needs
3. Case management services with other entities that also serve these children
4. Monitoring and improving the quality and appropriateness of care to children with special health care needs

Who are Children with Special Health Care Needs?

Children with special health care needs are those who:

1. Have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition
2. May have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal abnormalities or congenital abnormalities
3. Require health and related services of a type or amount beyond that required by children generally

Goals of Children with Special Health Care Need Case Management

The purpose of children with special health care needs case management is to:

1. Coordinate with family and providers to develop an individualized care plan.
2. Facilitate member access to needed services and resources.
3. Prevent duplication of services.
4. Optimize the member's physical and emotional health and well-being.
5. Improve the member's quality of life.
5. Provide transition planning.

Emphasis on Coordination

With proper identification of children with special health care needs, along with health risk assessment and development of an individualized care plan, CalOptima's case managers can refer children to the appropriate

service providers within the community. These service providers include California Children's Services (CCS), the Regional Center, Early Start, local education agency programs and the child welfare agency.

TIPS FOR SERVING CHILDREN WITH SPECIAL HEALTH CARE NEEDS

1. To support CalOptima's ability to case manage children with special health care needs, primary care providers should perform an initial health assessment within 120 days of enrollment for each new member under age 21. CalOptima uses the initial health assessment data to identify children with special health care needs.

2. If a provider identifies a child with special health care needs and believes he or she would benefit from case management, the provider should contact the CalOptima Care Coordination department at **714-246-8686**.

HOW TO MAKE A REFERRAL

CalOptima Direct (COD) and CalOptima Community Network (CCN) Members: If a provider identifies a CalOptima COD or CCN member with special health care needs, the provider can make a direct referral to CalOptima's Care Coordination department by calling **714-246-8686**, faxing to **714-571-2455**, or emailing to cmtriage@caloptima.org

CalOptima Members Assigned to a CalOptima Health Maintenance Organization (HMO), Physician Hospital Consortium (PHC) or Shared Risk Medical Group Health Network: If a provider identifies a CalOptima HMO, PHC or Shared Risk Medical Group member with special health care needs, the provider can make a direct referral by contacting the member's assigned health network. For health network contact information, see **Section B1: CalOptima Department and Program Contact Information.**

This section applies to the following CalOptima programs:

Medi-Cal

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

CalOptima centrally case manages members over the age of 21 with end-stage renal disease (ESRD) on dialysis. This function is not delegated to any CalOptima health network (**health maintenance organization (HMO), physician hospital consortium (PHC)** or shared risk medical group), with the sole exception of Kaiser Foundation Health Plan.

ESRD Patients Managed by CalOptima Community Network — Because members with ESRD have unique and specialized health care needs, members with ESRD are transferred from their health network into CalOptima Community Network.

HOW TO REFER MEMBERS WITH END-STAGE RENAL DISEASE

1. If a provider identifies a member who has end-stage renal disease, and the member is enrolled in a CalOptima health network, the provider should complete the Centers for Medicare & Medicaid Services (CMS) End-Stage Renal Disease Medical Evidence Report and send the completed form to the member's health network. For CalOptima health network contact information, see **Section B1: CalOptima Department and Program Contact Information**.

2. The member's health network will work with CalOptima's Care Coordination department to transition the member to CalOptima Community Network.

3. If a provider identifies a CalOptima Direct or CCN member with newly diagnosed ESRD, the provider should contact CalOptima's Care Coordination Department at **714-246-8686**, fax to **714-571-2455** or email to cmtriage@caloptima.org.

This section applies to the following CalOptima programs:

Medi-Cal

J4: HEMOPHILIA CASE MANAGEMENT

CalOptima centrally case manages any Medi-Cal member with hemophilia. This function is not delegated to any CalOptima health network (Health Maintenance Organization (HMO), Physician Hospital Consortium (PHC) or Shared Risk Medical Group), with the sole exception of Kaiser Foundation Health Plan.

Hemophilia Patients Managed by CalOptima Community Network — Because members with hemophilia have unique and specialized health care needs, members with hemophilia are transferred from their health network into CalOptima Community Network.

HOW TO REFER MEMBERS WITH HEMOPHILIA

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

- If a provider identifies a new member with hemophilia who is in CalOptima Direct or CalOptima Community Network, the provider should call CalOptima's Case Management department at **714-246-8686**, fax to **657-900-6143** or email to WCMhemophiliainbox@caloptima.org

CalOptima Policies and Procedures:

GG.1318: Coordination of Care for Hemophilia Members

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

J6: REFERRING MEMBERS FOR CASE MANAGEMENT

Case management is the coordination of care and services for members who have experienced a critical event or diagnosis, or are high-risk members. Typically, these members require extensive use of resources and need help navigating the health care system to facilitate the appropriate delivery of care and services.

OneCare (HMO SNP)'s contracted health networks are responsible for providing case management services for OneCare members. OneCare's health networks perform a comprehensive assessment of the member's condition, determine the available benefits and resources, develop and implement a case management plan, and monitor and follow up with the member.

OneCare (HMO SNP)'s health networks provide case management for both members with high-risk potential, as well as members with catastrophic illnesses/conditions.

High-Risk Criteria — Members with high-risk profiles exhibit one or more of the following criteria:

1. Active chronic diagnoses
2. Two or more hospitalizations in the past three months
3. Two or more emergency room visits in the past three months
4. Experiences a transition in care or change in health status
5. Has significant impairment in one or more activities of daily living (e.g., bathing, dressing, toileting or ambulating)
6. Has significant impairment in one or more of the instrumental activities of daily living (e.g., preparing meals, shopping, housekeeping, transportation, using the telephone or managing finances), particularly when no support system is present
7. Developmentally delayed member
8. Has evidence of malnutrition

Catastrophic Condition Criteria — A member may also qualify for case management due to a catastrophic illness or condition. Catastrophic illnesses include, but are not limited to:

1. Extensive burns (i.e., 30 percent or greater of body surface area)
2. Traumatic brain injuries
3. Multiple traumatic injuries
4. Organ transplant

5. Oncology patients not on hospice
6. Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)
7. Chronic major psychiatric illness
8. Guillain-Barre
9. Amytropic lateral sclerosis or other neuro-degenerative disease

Upon review of a member's prescription drug medications, OneCare (HMO SNP) or its contracted health networks may also include members who meet any of the following criteria for case management follow up:

1. Members taking eight or more medications
2. Members hospitalized for adverse medication reaction
3. Members who have multiple prescribing physicians
4. Prescription drug cost outliers

OneCare or its contracted health networks may consider members whose length of stay or cost incurred is above the standards established by nationally accepted standards or cost outliers as an indication for case management:

1. Members among the top three percent of utilization
2. Members who have annual ambulatory costs of $10,000 or more, excluding one-time durable medical equipment (DME)
3. Members who have an annual inpatient cost of $50,000 or more

HOW TO REFER A MEMBER FOR CASE MANAGEMENT SERVICES

If a provider identifies a member who would benefit from case management services, the provider should immediately contact the member's OneCare (HMO SNP) health network. For OneCare (HMO SNP) health network contact information, see **Section B1: CalOptima Department and Program Contact Information**.

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

J7: MODEL OF CARE

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) require all Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC). The SNP Model of Care is CalOptima's road map for care management policies, procedures and operational systems. There are four core elements of the OneCare Model of Care including:

- Description of the overall Special Needs Plan (SNP) population
- Care coordination
- Provider network
- Quality measurement and performance improvement

DESCRIPTION OF THE ONECARE POPULATION

The OneCare population is described by the following:

- Eligibility to participate in OneCare
- Social, cognitive, environmental factors, living conditions and co-morbid conditions of OneCare members
- Medical and health conditions impacting OneCare members
- Unique characteristics of the OneCare population
- Identification of the most vulnerable members of OneCare with specialized services listed for these members

Description of OneCare Population: Most Vulnerable Members

OneCare has identified the following special populations:

- Frail/disabled members
- Members in need of disease management
    a. Diabetes mellitus (DM)
    b. Congestive heart failure (CHF)
- Members with behavioral health needs
- Institutionalized members
- Members at end of life

CARE COORDINATION

Care coordination is defined as the following:

- **OneCare Staff Structure** — Administrative, clinical and oversight roles specific to OneCare including personal care coordinators (PCC)
- **Health Risk Assessment** — Assessment of the OneCare member's health needs
- **Individualized Care Plan (ICP)** — A plan of care for the OneCare member based on information from the Health Risk Assessment

- **Interdisciplinary Care Team (ICT)** — A team of medical, behavioral and ancillary providers, plus the OneCare member and an authorized representative. The ICT convenes to manage the member's care and assure care coordination.
- **Care Transition Protocols** — Guidelines on how to manage the OneCare member across the care continuum

Care Coordination: Staff Structure and Roles

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

- Administrative staff
- PCC staff
- Clinical staff
- Oversight staff

Care Coordination: Administrative Roles

OneCare administrative roles manage:

- Enrollment
- Eligibility
- Claims
- Grievances and provider complaints
- Information communication
- Collection, analysis and reporting of performance and health outcomes data

Care Coordination: Role of the PCC

The PCC at a health network or CalOptima is someone who helps members navigate the health care system and obtain the most optimal health care services, ensuring the best possible health care outcomes for all CalOptima members.

PCCs:

- The single point of contact for OneCare members
- Participate in ICT meetings
- Coordinate with and support other members of the ICT
- The liaison between the member, provider, health network and CalOptima

The CalOptima PCC:

- Administers the telephonic Health Risk Assessment (HRA)
- Inputs HRA responses into a data platform for RN review

Care Coordination: Clinical Roles

OneCare clinical roles:

- Advocate for, inform and educate members
- Identify and facilitate access to community resources
- Coordinate care
- Participate in ICT meetings
- Licensed clinical staff endorses the final ICP
- Review member's ICP goals

- Develop an outreach schedule for member care plan goals and needs
- Educate members on health risks and management of illnesses
- Empower members to be advocates of their health care
- Maintain and share records and reports
- Assure Health Insurance Portability and Accountability Act (HIPAA) compliance

Care Coordination: Oversight Roles

OneCare Oversight Roles:

- Monitor Model of Care implementation
- Evaluate effectiveness of Model of Care
- Assure licensure and competency
- Assure statutory and regulatory compliance
- Monitor contractual and delegated services
- Monitor interdisciplinary care teams
- Assure timely and appropriate delivery of services
- Assure providers use evidence-based clinical practice guidelines
- Assure seamless transitions and timely follow up

Care Coordination: Health Risk Assessment

OneCare Health Risk Assessment (HRA):

- CalOptima OneCare PCC administers initial (90-day) and an annual HRA for each member. The HRA is not delegated to the health networks.
- OneCare uses a standardized HRA tool.
- HRA is used to evaluate the medical, psychosocial, cognitive and functional needs with medical and behavioral health history.
- Results are used to develop the member's individualized care plan (ICP).
- HRA may be face-to-face, telephonic, electronic or paper-based.
- HRA identifies care needs that are categorized into care domains: Access, Coordination of Services, Health Monitoring, Medical-Acute, Medical-Chronic, Behavioral Health, Long-Term Care, and Long-Term Support Services (LTSS).

Care Coordination: Individualized Care Plan (ICP) Roles

OneCare ICP roles:

- An interdisciplinary care team develops the ICP for each OneCare member.
- Members or caregivers (at the member's request) are invited to participate in creating the ICP.
- The ICP is reviewed and revised annually or when health status changes.
- An ICP includes personalized goals and objectives, specific services and benefits, and measurable outcomes.
- The ICP goals and objectives are prioritized by member preference.
- The ICP is communicated to members, caregivers and providers.
- Records are per HIPAA and professional standards.
- The ICP is signed by the primary care provider (PCP).
- The ICP is shared with appropriate specialty providers.

Care Coordination: Interdisciplinary Care Team (ICT)

OneCare ICT Roles:

- Analyze and incorporate the results of the initial or annual HRA in the ICP, utilizing evidence-based guidelines.
- Collaborate to develop and annually update the member's ICP.
- Manage the medical, cognitive, psychosocial and functional needs of each member.
- Communicate the ICP to all caregivers for care coordination.
- Provide a copy of the ICP to the member in the member's preferred language, font and print size.

The ICT must include:

- Member
- PCP assigned to the member
- PCC

The ICT may also include:

- Behavioral health specialist
- Pharmacist
- Case manager
- Therapist (speech, physical)
- Nutritionist
- Appropriate specialist
- Pastoral specialist
- Health educator
- Disease management specialist
- Social worker

PROVIDER NETWORK

Provider network includes:

- Specialized expertise such as:
    a. Specialists
    b. Hospitalists
    c. Skilled nursing facility providers
    d. Behavioral health providers
    e. Pharmacists
    f. Crisis teams
    g. Allied health providers
    h. Ancillary services
    i. Substance abuse detoxification and rehabilitation services

- Use of evidence-based clinical guidelines and care transition protocols:
    a. Formalize oversight of provider network adherence to nationally recognized care standards

- OneCare Model of care training for the provider network:
    a. Assure provision and attestation of initial and annual MOC training

OneCare Provider Network

OneCare Provider Network includes:

- Contracting with board-certified providers

- Monitoring network providers to assure they use nationally recognized clinical practice guidelines
- Assuring that network providers are licensed and competent through a formal credentialing review
- Having a broad network of specialists including palliative care, pain management, chiropractors and psychiatrists
- Monitoring network adequacy to ensure access to care

OneCare Specialty Provider Network Programs

OneCare specialty provider network programs include:

- OneCare behavioral health program
- Specialty service programs including dialysis, transportation, durable medical equipment (DME) and home health
- Psychosocial programs such as homelessness and recuperative programs
- Specialty referral program that refers members to Community-Based Adult Services (CBAS), In-Home Supportive Services, housing assistance, Meals on Wheels and personal finance counseling
- Disease management and health education programs
- Community-based support programs such as Aging and Disability Resource Center (ADRC), Multipurpose Senior Services Program (MSSP), Office on Aging (OOA), and Dayle MacIntosh Center (independent living)

QUALITY MEASUREMENT (QM) AND PERFORMANCE IMPROVEMENT (PI)

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

- Model of Care (MOC) Quality Performance Improvement Plan
- Measurable goals and health outcomes measurements for the MOC
- Measuring member experience of care
- Ongoing performance improvement evaluation
- Dissemination of SNP quality performance related to the MOC

Performance Measurement

OneCare uses standardized quality improvement measures performance and health outcomes such as:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Disease management measures
- Utilization management measures
- Member satisfaction (surveys)
- Provider satisfaction (surveys)
- Ongoing monitoring of complaints and grievance summaries
- Tracking and assessing completion of MOC training

OneCare MOC Measurable Goals

OneCare evaluates measurable goals that:

- Improve access to medical, behavioral and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health care settings and providers.
- Improve access to preventive health services.
- Assure appropriate utilization of services.

- Assure cost-effective service delivery.
- Improve member health outcomes.

Measurement of Effectiveness

OneCare measures MOC effectiveness by collecting and reporting data on:

- Improvement in access to care
- Improvement in member health status
- Staff implementation of MOC
- Comprehensive HRA
- Implementation of ICP
- Provider network of specialized expertise
- Application of evidence-based practice
- Improvement of member satisfaction and retention

OneCare Clinical Guidelines

OneCare supports the physician management of chronic conditions by dissemination of best practices, evidence-based guidelines, and provider tool kits to promote education and adherence.

Summary

OneCare's Model of Care (MOC) creates a comprehensive strategy and infrastructure to meet the unique needs of the dual-eligible population by:

- Setting agencywide strategic goals
- Contracting with expert providers
- Striving to meet each member's unique medical, psychosocial, functional and cognitive needs

Community Resources, Social and Supportive Services

- Child Protective Services
- Local Education Agency Services
- Tuberculosis Directly Observed Therapy Services
- Women, Infants and Children (WIC) Services
- Coordination with Community Resources and Social Services

This section applies to the following CalOptima programs:

Medi-Cal

K1: CHILD PROTECTIVE SERVICES

CalOptima providers are required to report reasonable suspected or observed instances of child abuse or neglect within 36 hours of receiving the information concerning the event. These may include cases involving a pregnant minor.

Providers should report suspected or observed instances of child abuse or neglect to the Orange County Child Abuse Registry. By contacting the Child Abuse Registry, providers may be able to do the following:

1. Save a child's life.
2. Prevent further abuse or neglect.
3. Allow families to receive resources or services, which they may desperately need.
4. Make a valuable contribution to the protection of children and the prevention of abuse.

WHAT IS CONSIDERED CHILD ABUSE?

The law requires certain professionals to report suspicion and/or knowledge of child abuse including, but not limited to:

1. Physical abuse
2. Sexual abuse
3. Neglect
4. Cases of severe emotional abuse that constitute willful or unjustifiable punishment of a child

HOW TO REFER A PATIENT TO CHILD PROTECTIVE SERVICES

1. To report a case of suspected child abuse or neglect, call Orange County Child Protective Services at 714-940-1000 or 800-207-4464, 24 hours a day, seven days a week.
2. If the case is urgent, immediately report the suspected child abuse or neglect to the local law enforcement agency and to Orange County Child Protective Services using the 24-hour hot line noted above.
3. Child abuse reports and information given to child protective services agencies are always confidential by law.

CalOptima Policies and Procedures:

GG.1706: Child Abuse Reporting

This section applies to the following CalOptima programs:

Medi-Cal

K2: LOCAL EDUCATION AGENCY SERVICES

Local education agencies (LEAs) provide certain medically necessary preventive, diagnostic, therapeutic and rehabilitative services to children ages 3 years and older with special health care needs. A child may receive services from his or her local education agency in accordance with the child's Individualized Education Plan or Individual Family Service Plan.

What Services are Provided by a Local Education Agency? Local education agencies' educational support services may include the following when identified on the child's Individualized Education Plan or Individual Family Service Plan:

1. Health and mental health evaluations and education (assessments)
2. Nutritional assessment and education
3. Developmental assessment
4. Vision assessment
5. Psychosocial assessment
6. Psychological and counseling services
7. Physical therapy
8. Occupational therapy
9. Speech therapy
10. Audiology services
11. Nursing services
12. School health aid services
13. Medical transportation and mileage
14. Targeted case management services

Neither CalOptima nor its health networks are responsible for the provision or payment of local education agencies' services. However, CalOptima is responsible for providing a primary care provider and all medically necessary covered services for the member and shall ensure that the member's primary care provider cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. CalOptima shall provide case management and care coordination to the member to ensure the provision of all medically necessary covered diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with primary care provider participation.

IMPORTANT REMINDERS FOR PCPS ABOUT COORDINATING WITH LOCAL EDUCATION AGENCIES

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

2. PCPs should refer members to their local education agency.

3. PCPs need to be involved in the development of the child's Individualized Education Plan or Individual Family Service Plan.

4. The PCP needs to coordinate local education agency services for the child and needs to be aware of the local education agency services that the child may be receiving.

5. For more information about local education agencies services, please contact the Case Management department at **714-246-8686**.

CalOptima Policies and Procedures:

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

This section applies to the following CalOptima programs:

Medi-Cal

K3: TUBERCULOSIS DIRECTLY OBSERVED THERAPY SERVICES

Providers are responsible for furnishing tuberculosis (TB) services to CalOptima members, including TB screening, diagnosis, treatment of latent TB, case management and follow-up care. These services should be provided in accordance with the most recent guidelines from the American Thoracic Society and the Centers for Disease Control and Prevention (CDC).

The Orange County Health Care Agency's Pulmonary Disease Service (HCA/PDS) monitors TB cases in Orange County and uses Directly Observed Therapy to treat patients at risk of non-compliance for the treatment of TB.

Providers are required to report known or suspected cases of TB, as well as patients at risk of non-compliance for TB treatment, to the HCA/PDS.

ABOUT PULMONARY DISEASE SERVICES (TUBERCULOSIS CONTROL)

HCA Orange County TB Control offers evaluation and treatment of individuals with active or suspected active TB.

Orange County TB Control offers TB screening services (tuberculin skin testing, chest X-rays, symptom check and physician evaluation, when appropriate) to residents of Orange County who meet the following criteria:

1. Persons with two or more TB symptoms, such as cough, coughing up blood, fever, night sweats, unexplained weight loss
2. Persons with abnormal chest X-rays consistent with active TB disease
3. Persons in contact with an active TB disease case
4. Persons with documentation of a TB test that has gone from negative to positive within the last two years
5. Newly arriving refugees
6. Newly arriving immigrants required by the Centers for Disease Control and Prevention (CDC) / Division of Global Migration and Quarantine (DGMQ) to be evaluated for TB
7. Persons with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)
8. Clients of residential detoxification centers, and drug and alcohol treatment centers
9. Clients of shelters
10. Foreign-born persons resident in the United States less than two years

WHAT TO DO IF YOU IDENTIFY A PATIENT WITH TB

1. If you identify a member with a known or suspected case of TB, report the case to the HCA/PDS office within one working day of identification. Please note that you are still responsible for treating and managing the member's TB.

2. If you identify a member who is at risk of non-compliance for the treatment of TB, report the case to HCA/PDS TB control office for Directly Observed Therapy and CalOptima or the member's health network.

3. To report the case to the member's health network, see **Section B1: CalOptima Department and Program Contact Information** for a list of health network contact information. To report the case to CalOptima, call the CalOptima Case Management department at **714-246-8686**.

4. TB screening and treatment services are offered to eligible Orange County residents at:

   County of Orange Health Care Agency
   Tuberculosis Treatment and Prevention Services Clinic
   1725 W. 17th, Suite 101E
   Santa Ana, CA 92706
   714-834-8717

5. For further information regarding Tuberculosis Directly Observed Therapy Services, please visit the website for the Orange County Health Care Agency at www.ochealthinfo.com.

CalOptima Policies and Procedures:

GG.1128: Tuberculosis Services

This section applies to the following CalOptima programs:

Medi-Cal

K4: WOMEN, INFANTS AND CHILDREN (WIC) SERVICES

Low-income women and young children are eligible for services from the Supplemental Nutrition Program for Women, Infants and Children (WIC), a food and nutrition education program. WIC can reinforce and expand on the primary care provider's (PCP's) nutrition recommendations to help keep members at lower risk for health complications.

What Do WIC Services Include?

1. Individual/group counseling on nutrition/health education
2. Supplemental foods supporting nutrition education
3. Support and assistance with breastfeeding
4. Referrals to local agencies and community groups

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

1. Women who are pregnant, postpartum and breastfeeding
2. Infants (children under 1 year of age)
3. Children up to 5 years of age (including foster children)
4. Families with low to medium income (working families may qualify)

Participants must be Medi-Cal eligible or meet WIC income eligibility levels.

Neither CalOptima nor its health networks are responsible for the provision or payment of WIC services. However, as part of the referral process, providers shall document the hemoglobin or hematocrit laboratory values and the referral in the member's medical record. Primary care providers, as part of their initial health assessment of members or, as part of the initial evaluation of pregnant members, shall refer and document the referral of pregnant, breastfeeding or postpartum members or a parent/guardian of a child under the age of five to the WIC program as mandated by Title 42 CFR 431.635(c).

HOW TO REFER A PATIENT TO WIC

1. To make a referral to WIC, you may submit the referral to the WIC Office using any of the following documents:
    a. **Child Health and Disability Prevention (C**HDP) Program billing form (PM160)
    WIC referral form (to download a WIC referral form, please visit WIC Referral Form
    b. Prescription pad

2. Referrals should include the member's name, date of birth, height, weight, estimated date of confinement (EDC) if pregnant, hemoglobin or hematocrit results (if member is over 6 month old) and

documentation of any nutrition-related risk factors.

3. Instruct the patient to call a WIC agency for an appointment at 888-WIC-WORKS or 888-942-9675.

For more information, patients and health professionals may call WIC at 888-942-2229 or go online at www.cdph.ca.gov

CalOptima Policies and Procedures:

GG.1703: WIC Referrals

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

K5: COORDINATION WITH COMMUNITY RESOURCES AND SOCIAL SERVICES

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

OneCare and its contracted health networks are responsible for referring members to community and social service programs. These programs include, but are not limited to:

1. Programs that provide nutritional assistance or deliver meals to the home (e.g., Meals on Wheels)

2. Multipurpose Senior Services Program, which helps frail elderly members remain in their homes and avoid unnecessary institutionalization. For more information on the Multipurpose Senior Services Program, see Section **C5: Multipurpose Senior Services Program (MSSP)**.

3. In-Home Supportive Services, which provides in-home care so that elderly and disabled members can remain in their homes

4. Housing assistance, through agencies such as the Orange County Housing and Community Development Department

5. Adult Protective Services, which assists adults at risk for abuse

6. Legal Aid, which provides legal services to seniors, disabled people and other vulnerable individuals

7. Alzheimer's Association, which provides a 24/7 helpline, support groups and other resources for individuals with Alzheimer's and their families and caregivers

OTHER COMMUNITY RESOURCES

Along with the resources listed above for members enrolled in OneCare, all CalOptima members can access the Members section of the CalOptima website for information regarding other resources available to them. Listed below are two important examples of community resources available to members.

The Aging & Disability Resource Connection of Orange County (ADRCOC) is a collaborative effort led by CalOptima, the Orange County Office on Aging, and the Dayle McIntosh Disability Resource Center designed to streamline access to long-term care by developing "one-stop shop" centers in local communities that help older adults and individuals with disabilities make informed decisions about service and support options available to them.

ADRCOC programs provide information and assistance to individuals needing either public or private resources, professionals seeking assistance on behalf of their clients, and individuals planning for their future long-term care needs. ADRCOC programs work toward the goal of serving all individuals with long-term care needs, regardless of their age or disability.

Members may access services through walk-in at the Office on Aging telephonically or via the interactive website.

For more information about ADRCOC, providers and members can visit their website at www.adrcoc.org/ or call 800-510-2020, or 714-567-7500. Members can use the multi-lingual site to search by category, keyword, name, area served or location to find information for services such as:

1. Adult day health care
2. Disability services and products
3. Emergency hotlines
4. Financial assistance
5. Housing/shelter
6. Meals/food
7. Senior and community centers
8. Support groups
9. Transportation services
10. Veteran's services

2-1-1 Orange County is a comprehensive information and referral system that provides a resource database of health and human services and support, 24 hours a day, 7 days a week online and through their multi-lingual hotline. The website can be accessed at www.211oc.org/. By dialing 2-1-1, members may receive assistance for resources such as:

1. Food
2. Housing and utilities
3. 24-hour crisis and suicide counseling
4. Physical and mental health services
5. Elder services
6. Youth and child care issues
7. Substance abuse

8. Transportation

9. Shelter and government assistance programs

HOW TO COORDINATE WITH COMMUNITY RESOURCES

If a provider identifies a member who has specific family, home environment, nutritional or other social needs, the provider should contact CalOptima or the member's health network. The member's OneCare health network is responsible for evaluating the member and referring the member to the appropriate community and or social service resources.

For information on how to contact the member's OneCare health network, see Section **B1: CalOptima Department and Program Contact Information** of this manual.

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

CalOptima Policies and Procedures:

MA.6019: Coordination of Social Services

Customer Service

- Assistance from CalOptima Customer Service
- Member Liaison Program for Seniors and Persons with Disabilities (SPD)
- Health Network and PCP Selection
- Member Rights and Responsibilities
- New Member Welcome Materials
- Obtaining Access to Cultural and Linguistic Services
- Accessing Interpreter Services
- Tips for Documenting Interpreter Services
- Tips for Working with Interpreters
- Tips for Working with Limited English Proficient (LEP) Members
- Cultural Competency Training

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

N1: ASSISTANCE FROM CALOPTIMA CUSTOMER SERVICE

OneCare (HMO 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.

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 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, call CalOptima'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 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 programs:

Medi-Cal, OneCare (HMO SNP)

N2: MEMBER LIAISON PROGRAM FOR SENIORS AND PERSONS WITH DISABILITIES (SPD)

The Member Liaison Program is dedicated to helping seniors, members with disabilities or chronic conditions, and members without housing access health care services. The member liaison specialists work closely with health care providers, case managers and agencies throughout Orange County to help guide CalOptima members through the health care system. They help members obtain proper care, timely referrals to services, and connect them with health and community resources by providing direct intervention and or education for self-advocacy. The Member Liaison Program also offers monthly New Member Orientation presentations in our threshold languages to welcome new members and educate them on CalOptima programs as well as accessing benefits and services through our contracted providers.

The member liaison specialists can assist your CalOptima members by:

1. Scheduling appointments with a doctor
2. Arranging for non-emergency medical transportation
3. Resolving medication issues
4. Obtaining durable medical equipment including wheelchairs, wheelchair repairs, crutches and other supplies

HOW TO REFER MEMBERS TO THE MEMBER LIAISON PROGRAM

If you have a patient who may benefit from services of the Member Liaison Program, or if you want to obtain more information about services offered by the Member Liaison Program, please contact CalOptima's Customer Service department at **714-246-8500**, Monday through Friday, from 8 a.m. to 5:30 p.m.

Providers can use the following aid codes to determine member eligibility for seniors and persons with disabilities (SPD):

Eligible Member	Aid Code
Adult	53, 81, 86
Aged	10, 14, 16, 17, 1E, 1H
Blind/Disabled	20, 24, 26, 2E, 2H, 36, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P,6R, 6V, 6W, 6X, 60, 64, 65, 66, 67
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W

Eligible Member	Aid Code
Long-Term Care	13,23,53,63

For training and additional resources regarding seniors and persons with disabilities (SPD), visit the Providers section of the CalOptima website.

This section applies to the following CalOptima programs:

Medi-Cal

N3: HEALTH NETWORK AND PRIMARY CARE PROVIDER (PCP) SELECTION

CalOptima 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 and on an ongoing basis.

WHAT PROVIDERS SHOULD KNOW ABOUT THE SELECTION PROCESS

Most CalOptima members are eligible to enroll in a health network. For more information regarding eligible members, see Section **B1: CalOptima 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

1. New members to CalOptima 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'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.

4. If CalOptima 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 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 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 members are enrolled in CalOptima 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 payment.

If you have questions or need more information about CalOptima's provider and health network selection process, call CalOptima's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 5 p.m.

CalOptima Policies and Procedures:

DD.2008: Health Network Selection

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

N3: HEALTH NETWORK AND PRIMARY CARE PROVIDER (PCP) SELECTION

OneCare (HMO SNP) is committed to ensuring that its members have ample opportunity to select a primary care provider (PCP) and a health network, both when they join OneCare and on an ongoing basis.

WHAT PROVIDERS SHOULD KNOW ABOUT THE SELECTION PROCESS

OneCare members select a health network and a PCP upon enrollment. The following outlines the major elements of the health network and PCP selection process.

1. **Choice Upon Initial Enrollment Into OneCare (HMO SNP)**
    a. New members to OneCare complete an enrollment form during the enrollment process, and use the form to indicate a PCP and health network selection.
    b. New members to OneCare must select a PCP and health network at the time of enrollment.
    c. If a member does not select a PCP or health network, OneCare will assign the member to a PCP and or health network. OneCare will notify the member of the assignment, along with instructions about how to change the PCP or health network assignment.

2. **PCP Selection/Changes**
    a. New members to OneCare receive a Provider Directory Insert that explains the process of selecting PCP and health network.
    b. Members may choose any of the doctors listed in the OneCare (HMO SNP) Provider Directory as their PCP. If the PCP is not open to new members, we will ask the member to choose another PCP.
    c. Members may change their PCP and/or health network at any time by calling the OneCare Customer Service department at **877-412-2734**. The new selection will be effective on the first of the month following the date OneCare receives the member's request.

For questions or more information about OneCare's provider and health network selection process, call OneCare's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 5 p.m.

CalOptima Policies and Procedures:

MA.4010: Physician Group and PCP Selection and Assignment

This section applies to the following CalOptima programs:

Medi-Cal

N4: MEMBER RIGHTS AND RESPONSIBILITIES

CalOptima is required to inform its members of their rights and responsibilities, and ensure that members' rights and responsibilities are respected and observed. CalOptima provides this information to members in the Member Handbook upon enrollment, annually in the member newsletter, on CalOptima's website and upon request.

Providers are required to post the members' rights and responsibilities in the waiting room of the facility in which services are rendered.

CalOptima members have the right to:

1. Be treated with respect and dignity by all CalOptima and provider staff
2. Privacy and to have medical information kept confidential
3. Get information about CalOptima, our providers, the services they provide and their member rights and responsibilities
4. Choose a doctor within CalOptima's network
5. Talk openly with health care providers about medically necessary treatment options, regardless of cost or benefit
6. Help make decisions about their health care, including the right to say "no" to medical treatment
7. Voice complaints or appeals, either verbally or in writing, about CalOptima or the care we provide
8. Get oral interpretation services in the language that they understand
9. Make an advance directive
10. Access family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and emergency services outside CalOptima's network
11. Ask for a state hearing, including information on the conditions under which a state hearing can be expedited
12. Have access to their medical record and, where legally appropriate, get copies of, update or correct their medical record
13. Access minor consent services
14. Get written member information in large-size print and other formats upon request and in a timely manner appropriate for the format being requested

15. Be free from any form of control or limitation used as a means of pressure, punishment, convenience or revenge

16. Get information about their medical condition and treatment plan options in a way that is easy to understand

17. Make suggestions to CalOptima about their member rights and responsibilities

18. Freely use these rights without negatively affecting how they are treated by CalOptima, providers or the state

CalOptima members are responsible for:

1. Knowing, understanding and following their member handbook

2. Understanding their medical needs and working with their health care providers to create their treatment plan

3. Following the treatment plan they agreed to with their health care providers

4. Telling CalOptima and their health care providers what we need to know about their medical condition so we can provide care

5. Making and keeping medical appointments and telling the office when they must cancel an appointment

6. Learning about their medical condition and what keeps them healthy

7. Taking part in health care programs that keep them healthy

8. Working with and being polite to the people who are partners in their health care

HOW TO OBTAIN MORE INFORMATION ABOUT CALOPTIMA'S MEMBER RIGHTS AND RESPONSIBILITIES

CalOptima's Customer Service department can help providers with questions about CalOptima's PCP and health network selection process. To reach Customer Service, call **714-246-8500**, Monday through Friday, from 8 a.m. to 5:30 p.m.

CalOptima Policies and Procedures:

DD.2001: Member Rights and Responsibilities

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

N4: MEMBER RIGHTS AND RESPONSIBILITIES

OneCare (HMO 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.

RIGHTS:

- Receive information about OneCare, available programs and services, doctors, providers, health care facilities, and drug coverage and costs, in a manner the member will understand.
- Be treated with dignity, fairness and respect at all times.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, or retaliation or convenience.
- Receive health care services without discrimination based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, sexual orientation, genetic information, evidence of insurability, or geographical location within the service. area.
- Have personal and health information kept private.
- Have timely access to covered services, including doctors, specialists, hospitals and medications.
- Receive emergency care where and when it is needed.
- Know and understand his or her medical treatment choices/options and risks; participate in decisions about his or her health care, including the option to refuse care; and receive an explanation if coverage or care is denied.
- File complaints, including complaints about quality of care, to ask for reconsideration of decisions OneCare has made, and to be informed of procedures for filing complaints, appeals and grievances.
- Be fully informed of all procedures for service authorization, quality assurance programs, disenrollment and other procedures that may affect his or her access to care.
- Select a primary care provider (PCP) from the panel and request relevant credentialing information regarding a PCP.
- Request a second opinion.
- Receive information regarding advance directives.
- Access his or her medical records and have the confidentiality of his or her medical records protected.
- Make recommendations regarding the OneCare Member Rights and Responsibilities Policy.

RESPONSIBILITIES:

- Become familiar with the covered services and rules that members must follow to obtain these services.
- Inform OneCare of any other health insurance drug coverage the member has in addition to OneCare.
- Inform providers that the member is enrolled in OneCare.
- Learn about his or her medical condition and what keeps him or her healthy.
- Actively participate in the health care programs that keep him or her well, including following the treatment plans and instructions that the member and his or her doctors agree upon.
- Inform his or her PCP of his or her medical condition and any medications the member is taking.
- Make and keep appointments for checkups and inform the PCP's office when he or she must cancel an appointment.
- Carefully review, understand and follow the guidelines in the OneCare Member Handbook/Evidence of Coverage (EOC) provided to all members.

This section applies to the following CalOptima programs:

OneCare (HMO SNP)

N5: NEW MEMBER WELCOME MATERIALS

Upon enrolling in OneCare, all new OneCare members receive two initial mailings that contain information to help members access OneCare's programs and services.

All members also receive a newsletter annually with articles on health education, service and benefit reminders, and information about how to use the health plan.

PACKET 50: ONECARE WELCOME PACKET

The OneCare Welcome Packet is sent to eligible members within 10 calendar days after receipt of the completed enrollment form. Contents include:

1. Evidence of Coverage (EOC)
2. Acknowledgement of Completed Enrollment Letter
3. OneCare ID Card
4. Notice of Privacy Practices
5. Notice of Nondiscrimination
6. Multi-Language Insert
7. Provider Directory and Formulary Insert

PACKET 50A: ONECARE WELCOME SUBSEQUENT PACKET

1. New Member Orientation Invitation
2. Silver & Fit Welcome Letter and Brochure

PACKET 52: ONECARE NEW MEMBER WELCOME PACKET

The OneCare New Member Welcome Packet is sent to members within 10 calendar days after receipt of the enrollment confirmation from the Centers for Medicare & Medicaid Services. Contents include:

1. Confirmation of Enrollment Letter

OBTAINING MORE INFORMATION ABOUT THE NEW MEMBER MATERIALS

For questions about new member materials packets, or more information about any of the contents of the packets, call CalOptima's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 5 p.m.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

N6: OBTAINING ACCESS TO CULTURAL AND LINGUISTIC SERVICES

State and federal regulations require CalOptima to make interpreter and translation services for limited English proficient (LEP) members available. CalOptima is also required to facilitate, promote and provide training in cultural competency for its staff, as well as for health network staff and CalOptima providers.

CalOptima's Cultural and Linguistic Services program provides and facilitates interpreter and translation services, and also coordinates training and events to promote cultural sensitivity and competency.

The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) periodically audit CalOptima's Language Assistance Program which includes interpreter and translation services, as well as on its conduct of cultural competency training. DHCS and CMS auditors may select individual provider offices to review as a part of this audit to verify whether LEP members are informed of the availability of language assistance and have been offered interpreter services. CalOptima will contact, in advance, provider offices selected by the DHCS to participate in its cultural and linguistic services audit.

OBTAINING MORE INFORMATION ABOUT CALOPTIMA'S CULTURAL AND LINGUISTIC SERVICES

To register for CalOptima's Awareness and Education Seminars, contact CalOptima's Customer Service department at **714-246-8500**, Monday through Friday, from 8 a.m. to 5:30 p.m. or email Cultural and Linguistic Services at: culturallinguistic@caloptima.org.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

N7: ACCESSING INTERPRETER SERVICES

Federal and state regulations require CalOptima to provide interpreter services to members with limited English proficiency. Limited English proficient (LEP) members include those who have a limited ability to read, speak, write or understand English.

Providers may request interpreter services for their CalOptima patients with limited English proficiency. Providers may request either telephonic or face-to-face interpreter services, depending upon the situation.

For help in identifying your patient's preferred language, see the Providers section of the CalOptima website.

HOW TO REQUEST INTERPRETER SERVICES

1. Verify the member's eligibility and identify if the member is enrolled in a health network or CalOptima Direct.

2. Determine whether telephonic or face-to-face interpreter service is needed.
    a. Telephonic interpreter service is recommended for urgent situations or short and simple conversations. This service is available 24 hours a day, seven days a week.
    b. Face-to-face interpreter service, including sign language, is recommended when complicated or extensive explanation of treatment or symptoms is required. This service is available for scheduled medical appointments in an ambulatory setting, and requires at least five working days' advance notice.

3. Please have the following information ready at the time of the request:
    a. Member's name
    b. Member's Card Identification Number
    c. Member's gender
    d. Member's age
    e. Date of appointment
    f. Time of appointment
    g. Language needed
    h. Approximate duration
    i. Type of visit
    j. Name of doctor/facility
    k. Address of appointment/location
    l. Phone number of appointment/location

4. If the member is in CalOptima Direct, call CalOptima's Customer Service department at **714-246-8500**. Prior authorization is **not** required.

5. If the member is in a health network, please use the list below to contact the member's health network after verifying eligibility. The member's health network will work with you and the member to coordinate all interpreter services.

HEALTH NETWORK INTERPRETER SERVICES CONTACT LIST

Health Network	Telephonic Interpreter Service Contact	Face-to-face Interpreter Service Contact
ADOC Medical Group	844-292-5173	844-292-5173
Alta Med Health Services	877-462-2582	877-462-2582
AMVI Care Health Network	866-796-4245	866-796-4245
Arta Western Health Network	800-788-8879 or via fax referral request: 949-567-0236 or via online referral request: www.HCP-Connect.com	800-788-8879 or via fax referral request: 949-567-0236 or via online referral request: www.HCP-Connect.com
CHOC Health Alliance	800-424-2462	800-424-2462
Family Choice Health Network	Language Line: 800-874-9426	800-611-0111
Kaiser Permanente	800-464-4000 or 800-777-1370 (TDD/TTY)	800-464-4000 or 800-777-1370 (TDD/TTY)
Monarch Family HealthCare	888-656-7523	888-656-7523
Noble Mid-Orange County	888-880-8811	888-880-8811 Ask for Utilization Department
Prospect Medical Group	800-708-3230	800-708-3230 or fax request to: 714-560-7305 or submit request online: www.prospectmedical.com
Regal Medical Group	844-292-5173	844-292-5173
Talbert Medical Group	800-297-6249 or via fax referral request: 714-436-4408 Or via online referral request: www.HCP-Connect.com Need access code for interpreter services	800-297-6249 or via fax referral request: 714-436-4408 Or via online referral request: www.HCP-Connect.com
United Care Medical Network	877-225-6784	877-225-6784

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

N8: TIPS FOR DOCUMENTING INTERPRETER SERVICES

Federal and state regulations require that CalOptima, its health networks, medical groups and providers offer free interpreter services to limited English proficient members. Regulations also require CalOptima to ensure that qualified interpreters are professionally trained, culturally competent, and are versed in medical terminology and managed care concepts.

Because of these requirements, it is important that practices document when members use or refuse to use qualified interpreter services. Documenting refusal of interpreter services in the member record not only protects the provider and the provider's practice, it also ensures consistency when medical records are monitored through site reviews or audits to ensure adequacy of CalOptima's Language Assistance program.

TIPS FOR DOCUMENTING INTERPRETER SERVICES

1. CalOptima recommends using professionally trained interpreters and documenting the use of the interpreter in the member's medical record.

2. If the member was offered a qualified interpreter and refused the service, it is important to note that refusal in the member record for that visit.

3. Using a family member or friend to interpret should be discouraged. However, if the member insists on using a family member or friend, it is extremely important to document this in the medical record, especially if the chosen interpreter is a minor.

4. Smart Practice Tip: Consider offering a telephonic interpreter in addition to the family member/friend to ensure accuracy of interpretation.

5. For all limited English proficient members, it is a best practice to document the member's preferred language in paper and or electronic medical records in the manner that best fits your practice flow.*
    a. For a paper record, one way to do this is to post color stickers on the member's chart to flag when an interpreter is needed. (For example, Orange = Spanish, Yellow = Vietnamese, Green = Russian, etc.)*

*Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers; www.iceforhealth.org/.

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

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 programs:

Medi-Cal, OneCare (HMO SNP),

N10: TIPS FOR WORKING WITH LIMITED ENGLISH PROFICIENT (LEP) MEMBERS

Regulations require that CalOptima, its contracted health networks, medical groups and providers offer free interpreter services to limited English proficient (LEP) members. Interpreters must be professionally trained and versed in medical terminology and health care benefits. As a result, it is important that providers know how to identify, offer and access interpreter services for LEP members.

TIPS FOR WORKING WITH LEP MEMBERS

1. **Who are considered LEP members?**
   Individuals who do not identify English as their preferred language and who have a limited ability to read, speak, write or understand English, may be considered LEP.

2. **How to identify LEP members over the phone.**
   An LEP member may exhibit the following characteristics:
   a. Is quiet or does not respond to questions
   b. Responds with a simple "yes" or "no," or gives inappropriate or inconsistent answers to your questions
   c. May have trouble communicating in English or you may have a very difficult time understanding what he or she is trying to communicate
   d. Identifies as LEP by requesting language assistance

3. **How to offer interpreter services to an LEP member when member speaks no English and you are unable to discern the language.**
   If you are unable to identify the language spoken by the LEP member, you should request telephonic interpreter services to identify the language needed. For more information on accessing interpreter services, see **Section N7: Accessing Interpreter Services**.

4. **How to best communicate with an LEP member who speaks some English but with whom you are having difficulty communicating.**
   Speak slowly and clearly with the member. Do not speak loudly or shout. Use simple words and short sentences.

5. **How to offer interpreter services to the member.**
   Here are a couple of recommended ways to offer interpreter services:
   a. "I think I am having trouble explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak?"
   b. "I am going to connect us with an interpreter. Which language do you speak?"

6. **Best practice to capture language preference.**
   For LEP members, it is a best practice to capture the member's preferred language and record it in the plan or provider's member data system. You may want to consider asking the following question:

"In order for (provider's name) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?"

This section applies to the following CalOptima programs:

Medi-Cal, OneCare (HMO SNP),

N11: CULTURAL COMPETENCY TRAINING

CalOptima regularly conducts cultural competency training seminars that are open to providers, provider office staff and health network staff. The purpose of the training is to:

1. Furnish information and education on the cultural concerns and needs of CalOptima's member population.

2. Provide tips and resources to help enhance services provided to CalOptima members.

3. Comply with regulatory mandates.

CalOptima holds quarterly Awareness and Education Seminars at its offices located at 505 City Parkway West, Orange, CA 92868.

HOW TO SIGN UP FOR CULTURAL COMPETENCY TRAINING

To register for CalOptima's Awareness and Education Seminars, contact CalOptima's Customer Service department at **714-246-8500**, Monday through Friday, from 8 a.m. to 5:30 p.m., or email Cultural and Linguistic Services at: culturallinguistic@caloptima.org.

Provider Responsibility

- Role of the Primary Care Provider (PCP)

This section applies to the following CalOptima programs:

Medi-Cal

Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) plays the central role in structuring care for CalOptima members. The PCP is the main provider of health care services for CalOptima members and is responsible for the delivery of health care to his or her assigned members. CalOptima's model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

RESPONSIBILITIES OF THE PCP

PCP responsibilities include, but are not limited to:

1. Provide care for the majority of health care issues presented by the member, including preventive, acute and chronic health care.

2. Furnish risk assessment, treatment planning, coordination of medically necessary services, referral, follow up and monitoring of appropriate services and resources required to meet the needs of the member.

3. Case manage assigned members to ensure continuity of care, facilitate access to appropriate health services, reduce unnecessary referrals to specialists, minimize inappropriate use of the emergency department, maintain appropriate use of pharmacy benefits, and identify appropriate health education materials and interventions.

4. Assure access to care 24 hours a day, seven days a week, including accommodations for urgent care, performance of procedures and inpatient rounds.

5. Coordinate and direct appropriate care for members, including:
    a. Initial assessments
    b. Preventive services in accordance with established standards and periodicity schedules as required by age and according to the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF)
    c. Second opinions
    d. Consultation with referral specialists
    e. Follow-up care to assess results of primary care treatment regimen and specialist recommendations
    f. Special treatment within the framework of integrated, continuous care

6. Coordinate the authorization of specialist and non-emergency hospital services for members.

7. Contact and follow up with the member when the member misses or cancels an appointment.

8. Record and document information in the member's medical record, including:
    a. Member office visits, emergency visits and hospital admissions
    b. Problem lists, including allergies, medications, immunizations, surgeries, procedures and visits
    c. Efforts to contact the member
    d. Treatment, referral and consultation reports
    e. Lab and radiology results ordered by the PCP

9. A physician must countersign and date a sample of, at minimum, five percent (5%) of the medical records within thirty (30) calendar days of the date of treatment by the PA, NP, CNP. For services rendered by a CNM, a physician countersignature is not required.

10. A physician must review, countersign, and date any Schedule II drugs ordered by the PA, within seven (7) calendar days. When Schedule II drugs are furnished by an NP, CNP, and/or CNM a countersignature by a physician is not required. The NP, CNP and/or CNM shall adhere to the provisions of their standardized procedures when furnishing Schedule II drugs to address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

11. Make reasonable attempts to communicate with the member in the member's preferred language, using available interpretation or translation services.

12. If the member has a behavioral health diagnosis, coordinate the member's care with the member's behavioral health provider or behavioral health case manager.

CalOptima Policies and Procedures:

GG.1110: Primary Care Practitioner Definition, Role and Responsibilities

This section applies to the following CalOptima programs:

OneCare (HMO SNP),

Q1: ROLE OF THE PRIMARY CARE PROVIDER (PCP)

The primary care provider (PCP) plays the central role in overseeing the care for CalOptima members. The PCP is the main provider of health care services for OneCare members and is responsible for the delivery of health care to his or her assigned members. CalOptima model of care is built around the PCP, with the PCP as the center of a multidisciplinary team coordinating services furnished by other physicians or providers to meet the needs of the member.

RESPONSIBILITIES OF THE PCP

PCP responsibilities include, but are not limited to:

- Provide care for the majority of health care issues presented by the member, including preventive, acute and chronic health care.
- Furnish appropriate care for the health care problems presented by a member, including preventive, acute and chronic health care, and provide referrals to other practitioners for services.
- Provide risk assessment, treatment planning, coordination of medically necessary services, referral, follow up, and monitoring of appropriate services and resources required to meet a member's health care needs.
- Assure access to care 24 hour a day, seven days a week, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency and back-up coverage in the PCP's absence.
- Provide basic medical case management to assigned members:
    a. Ensure continuity of care for the member and an interactive relationship between the PCP and the member.
    b. Initiate and maintain in the medical record an individualized care plan (ICP) that addresses areas identified through the comprehensive assessment.
        i. The PCP participates on the 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. Increase member satisfaction.
    e. Facilitate access to appropriate health services.
    f. Ensure appropriate use of specialty and hospital services.
    g. Ensure the appropriate use of the pharmacy and drug benefit, including medication reconciliation.
    h. Screen health status, monitor and provide preventive health services.
    i. Identify and provide appropriate health education to improve a member's understanding of the importance of a healthy lifestyle and disease-specific interventions.
- Verify eligibility of the member at the time services are provided.
- Keep office waiting times to a maximum of 45 minutes.
- Coordinate and direct appropriate care for members, including:
    a. Review of the comprehensive Health Risk Assessment (HRA) that is completed within 90 calendar days after enrollment in OneCare, and schedule an appointment for high-risk members within 30 calendar days.

   b. Provide preventive services in accordance with established standards and periodicity schedules, as required by age and according to the United States Preventive Services Task Force (USPSTF), the American College of Physicians (ACP), the American Academy of Family Medicine (AAFM), and relevant indicators of deficits.
   c. Provide second opinions as necessary.
   d. Consult with referral specialists (including providing necessary history and clinical data to assist the specialists with their examination of the member).
   e. Provide follow-up care to assess results of the primary care treatment regimen and specialist recommendations.
   f. Provide special treatment within the framework of integrated, continuous care.
- Coordinate the authorization of specialist and non-emergency hospital services for a member and ensure that services generated from referrals are initiated within 30 calendar days after the visit at which the referral was made.
- Assure the provision of basic clinical services including primary evaluation and treatment of acute and chronic medical and surgical problems in all systems.
- Contact and follow up with the member when the member misses or cancels an appointment.
- Record the following information in the medical record and make records available for review upon request by CalOptima, the member's health network, and applicable federal and state oversight agencies:
   a. Member office visits, emergency visits and hospital admissions
   b. A problem list that includes allergies, medications, immunizations, surgeries, procedures and visits
   c. Efforts to contact a member
   d. Treatment, referral and consultation records
   e. Laboratory and radiology results ordered by the PCP
   Individualized Care Plan (ICP)
- Adhere to the following to ensure that the member's medical record documentation is accurate:
   a. The documentation of each encounter includes the reason for encounter and relevant history, physical examination findings, and prior diagnostic test results, assessment, clinical impression, or diagnosis, medical plan of care, date and legible identity of the rendering provider.
   b. The current procedural terminology (CPT) and current International Classification of Diseases (ICD) codes reported on the health insurance claim form or billing statement supported by the documentation in the medical record
- Facilitate and ensure quality of care by establishing procedures to contact a member when the member misses an appointment that requires rescheduling for additional visits and following up on referrals to a specialist for care.
- Assist the member with the grievance and appeals processes as set forth in CalOptima policies.
- Coordinate the transfer of the member and his or her medical records to another provider upon notification of a planned or unplanned transition of care episode, or upon request by the member, the member's health network or CalOptima.
- Make reasonable attempts to communicate with a member in the member's preferred language, using interpretation or translation services available through a member's health network.
- Preserve the dignity of the member.
- If the member has a behavioral health diagnosis, coordinate the member's care with the member's behavioral health provider or behavioral health case manager.

CalOptima Policies and Procedures:
GG.1110: Primary Care Practitioner Definition, Role and Responsibilities
MA.9001: Complaint Process
MA.9002: Member Grievance Process
MA.9003: Standard Service Appeal
MA.9004: Expedited Service Appeal
MA.9005: Payment Appeal
MA.9006: Provider Grievance Process
MA.9007: Appeal Process for Member Discharge from Inpatient Facility
MA.9008: Appeal Process for Coverage Termination of SNF, Home Health, or CORF services Payment

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: February 27, 2020

ALL PLAN LETTER 20-003
SUPERSEDES ALL PLAN LETTER 19-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NETWORK CERTIFICATION REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on the Annual Network Certification (ANC) requirements pursuant to Title 42 of the Code of Federal Regulations (CFR) sections 438.68, 438.206, and 438.207, and Welfare and Institutions Code (WIC) section 14197.[2, 3]

BACKGROUND:
The ANC provides a prospective look at the MCP's network for the upcoming contract year (CY).[4] MCPs are required to annually submit documentation to the Department of Health Care Services (DHCS) to demonstrate the adequacy of their networks. DHCS reviews all MCP network submissions and provides an assurance of the MCPs' compliance with ANC standards to the Centers for Medicare and Medicaid Services (CMS) before the CY begins.[5]

POLICY:
Federal and state law and regulation require DHCS to certify each MCP's aggregate network every year.[6, 7] MCPs are required to annually submit ANC documentation to

[1] This APL applies to all MCPs and Senior Care Action Network (SCAN).
[2] 42 CFR Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.
[3] WIC section 14197 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14197.
[4] For purposes of this APL, the CY is the MCP's fiscal year except for the following MCPs: Family Mosaic, AIDS Healthcare Foundation, and SCAN Health Plan. The CY for those MCPs is the calendar year.
[5] 42 CFR section 438.207(d).
[6] A network is defined as Primary Care Physicians (PCPs), specialists, hospitals, pharmacies, ancillary providers, facilities, and any other providers that subcontract with an MCP for the delivery of Medi-Cal covered services.
[7] 42 CFR section 438.207(c)(2); WIC section 14197.

DHCS to demonstrate their capacity to serve the anticipated membership in their service areas.[8, 9]

Specifically, DHCS must ensure that MCPs:

- Contract with the required number and mix of primary and specialty care providers;
- Provide medically necessary services needed for their anticipated membership and utilization;
- Confirm the geographic location of network providers complies with time and distance standards; and
- Comply with service availability, physical accessibility, out-of-network (OON) access, timely access, continuity of care, and 24/7 language assistance requirements.[10,]

I. MEDI-CAL MANAGED CARE HEALTH PLANS ANNUAL NETWORK CERTIFICATION

A. Annual Network Certification Components

1. Network Providers[11]

Each MCP must maintain and monitor an appropriate network that includes the following network provider types to ensure the MCP's network has the capacity to provide all medically necessary services:

- Adult and pediatric PCPs, including non-physician medical practitioners;[12]
- Obstetrician-gynecologists (OB/GYN);
- Adult and pediatric core specialists;[13]

---

[8] 42 CFR sections 438.68, 438.206, and 438.207.
[9] For purposes of this APL, service area and reporting unit have the same meaning. Reporting units are outlined in Attachment B of this APL.
[10] 42 CFR section 438.207(a) - (b); WIC section 14197.
[11] For more information on networks and network providers, see APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, or any subsequent revision to this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[12] Non-physician medical practitioners include nurse practitioners, physician assistants, and certified nurse midwives (CNMs).
[13] Core specialists are listed in Attachment A of this APL.

- Adult and pediatric mental health outpatient providers;[14]
- Hospitals;
- Pharmacies; and
- Ancillary services.[15]

Additionally, MCPs operating in County Organized Health Systems (COHS) or Cal MediConnect counties must contract with and monitor an appropriate network of Managed Long Term Services and Supports (MLTSS) providers.[16]

2. Network Capacity and Ratios

Network Capacity

In order to support current and anticipated membership, MCPs must meet or exceed network capacity requirements as defined in the MCP contract.[17] Imperial, Regional, San Benito, Two-Plan, and Geographic Managed Care plan model MCPs must maintain a network capacity to serve 60% of all eligible members in their service areas or the current member enrollment in the MCP, whichever is higher. COHS plan model MCPs are required to have a network with the capacity to serve 100% of eligible members in the county. MCPs must adjust the number of network providers proportionally to accommodate any changes in enrollment.

Provider to Member Ratios

MCP networks must meet the full time equivalent (FTE) ratios of one FTE PCP to every 2,000 members and one FTE physician to every 1,200 members.[18] DHCS calculates the network providers' FTE for adult and pediatric PCPs and total physicians as described in Attachment B, Exhibit A-2.[19] MCPs may use non-physician medical practitioners to improve primary care access; however, they must not include them for purposes of calculating the PCP and Total Physician Ratios.

---

[14] State Plan Amendment (SPA) 14-012. SPAs are available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/ApprovedSPA.aspx.
[15] MCP Contract, Exhibit A, Attachment 6, Network Composition. MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[16] MLTSS providers include Community Based Adult Service providers, Long Term Care providers, Multipurpose Senior Services Program, Intermediate Care Facilities and Skilled Nursing Facilities.
[17] MCP Contract, Exhibit A, Attachment 6, Network Capacity.
[18] MCP Contract, Exhibit A, Attachment 6, Provider to Member Ratios.
[19] Attachment B of this APL serves as the ANC Instruction Manual. The ANC Instruction Manual provides MCPs with policy details, ANC checklists, and ANC scenarios.

MCPs are required to meet provider to member ratios for adult and pediatric outpatient mental health providers to ensure access to MCP-covered outpatient non-specialty mental health services. DHCS annually calculates the number of providers necessary to cover each service area by taking into account service utilization, dedicated provider time for providing mental health services, and expected usage by adult and pediatric populations.[20] DHCS will provide each MCP with the required number of providers to cover their service areas.

Additionally, in order to ensure consistency amongst delivery systems and compliance with mental health parity requirements, MCPs that contract with DHCS to provide Specialty Mental Health Services (SMHS) must meet the provider to member ratios by which the county mental health plans are held for outpatient SMHS and psychiatry services.

3. Mandatory Providers

In accordance with WIC section 14087.325, MCPs must offer to contract with each of the following mandatory provider types in their service area, where available: Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).[21] Furthermore, CMS State Health Official letter (SHO) #16-006 mandates that MCPs contract with at least one FQHC, one RHC, and one Freestanding Birthing Center (FBC) in their service areas, where available.[22]

Further, MCPs must contract with a minimum of one CNM and one licensed midwife (LM) in their service areas, where available, in accordance with state

[20] MCP Contract, Exhibit A, Attachment 20, Outpatient Mental Health Services Providers.
[21] WIC section 14087.325 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14087.325. https://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14087-325.html.
[22] SHO Letter #16-006 is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf.

and federal network adequacy requirements.[23, 24, 25] MCPs that have a FBC in their network are not exempted from the requirement to contract directly with a minimum of one CNM and one LM. MCPs must ensure CNMs and LMs are properly enrolled and credentialed when establishing a direct contract with these providers. For additional information on FBC, CNM, and LM requirements, see APL 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services, including subsequent revisions to this APL.

Federal and state laws and regulations provide protections for American Indians and American Indian Health Services.[26] Indian Health Facilities (IHFs) are not required to contract with MCPs but can voluntarily enter into a contract with an MCP at any time. However, MCPs are required to offer to contract with each IHF in their service area(s).[27] MCPs that do not have an IHF in their network must allow eligible members to obtain services from an OON IHF.[28]

MCPs must annually demonstrate efforts to improve access to services customarily provided by mandatory providers. MCPs that do not have a contract with a mandatory provider must submit documentation to DHCS for review and approval detailing the reasons the MCP was unable to contract, as outlined in Attachment B, Exhibit A-3.

4. Time and Distance Standards

DHCS established network adequacy standards in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services.[29, 30] These standards require MCPs to meet both time and

[23] MCP Contract, Exhibit A, Attachment 9, Nurse Midwife and Nurse Practitioner Services.
[24] WIC section 14132.39 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.39. WIC section 14132.4 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.4.
[25] 42 of the United States Code (USC) section 1396d(a)(17). The USC is available at: http://uscode.house.gov/.
[26] 42 CFR section 438.14; 22 CCR section 55120.
[27] Title 22 of the California Code of Regulations (CCR) section 55120. 22 CCR section 55120 is available at: https://govt.westlaw.com/calregs/Search/Index.
[28] 42 CFR section 438.14.
[29] 42 CFR section 438.207.
[30] For more information on network adequacy standards, see Attachment A of this APL.

distance standards based on county population density.[31, 32] Time and distance standards apply to the following provider types:[33]

- Adult and pediatric PCPs;
- Adult and pediatric core specialists;
- OB/GYN primary care services;
- OB/GYN specialty care services;
- Hospitals;
- Adult and pediatric mental health providers; and
- Pharmacies.

If a member elects to use an OB/GYN as their PCP and the OB/GYN agrees to act as the member's PCP, the MCP must ensure timely access is met even if time and distance standards are not met for that member.[34]

MCPs must create and submit accessibility analyses and narratives, if applicable, to demonstrate compliance with time and distance standards. The accessibility analyses must demonstrate coverage of the MCP's entire service area, for all ZIP codes, to account for all current and anticipated membership. Attachment B, Exhibit B details the submission requirements pertaining to the accessibility analyses and narratives.

DHCS may authorize MCPs to use telehealth and mail order pharmacy(ies), where necessary, for purposes of complying with time and distance standards (see Section B-3: "Telehealth" and Section B-4: "Mail Order Pharmacy" of this APL).[35]

5. Timely Access

Timely Access Survey
DHCS conducts a timely access survey that measures compliance with appointment time standards.[36] DHCS includes the annual results of the retrospective timely access survey as a component of the ANC. The survey includes a statistically valid random sample of network providers to confirm the first three available times for urgent and non-urgent appointments for

[31] WIC section 14197(b).
[32] For more information on county populations, see Attachment A of this APL.
[33] 42 CFR section 438.68(b).
[34] Health & Safety Code section 1367.69.
[35] WIC section 14197(e)(4).
[36] For more information on network adequacy standards, see Attachment A of this APL.

pediatric and adult members; the availability of interpreter services; and the languages spoken by the network providers or provider site locations.

Additionally, as part of the timely access survey, DHCS contacts each MCP call center to confirm call center compliance with wait time standards and call center awareness of a member's right to receive interpretation services.[37, 38]

DHCS provides the results of its timely access survey to MCPs on a quarterly basis and annually determines the rate of compliance. MCPs must submit a response to any timely access deficiencies found in the quarterly survey results and identify any changes or corrections necessary to achieve compliance with timely access requirements.

Audits & Investigations Timely Access Verification Study
DHCS' Audits and Investigations Division (A&I) routinely performs medical review audits of MCPs. A&I reviews the MCPs' infrastructure to assess compliance with all access to care requirements, including but not limited to, the following:

- Service availability;
- Physical accessibility;
- OON access;
- Timely access;
- Continuity of care; and
- 24/7 language assistance.

If there are non-compliant findings in Category 3 – Access and Availability of the A&I medical audit, those findings are noted in the MCP's ANC Corrective Action Plan (CAP).

B. Medi-Cal Managed Care Health Plan Alternative Access Standards

1. Alternative Access Standard Request

MCPs must submit an Alternative Access Standard (AAS) request to DHCS for review and approval if the MCP is unable to meet time and distance standards and has exhausted all reasonable contracting options with nearer

[37] 28 CCR section 1300.67.2.2(c)(10).
[38] 22 CCR section 53853(c).

providers.[39, 40] MCPs must submit all AAS requests, even if they were previously approved, on an annual basis or any time a network change results in the MCP not meeting time and distance standards.

In order for the request to be considered for the ANC, MCPs must submit the AAS request to DHCS with the ANC exhibits no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). DHCS will make best efforts to approve any AAS requests received after the deadline but cannot guarantee a decision prior to the CMS submission deadline.

Attachment B, Exhibit C, details the submission requirements for AAS requests. MCPs must explain the facts and circumstances for each AAS request and detail at a minimum, the following:

- Name and address of nearest network provider;
- Driving time/distance to the nearest network provider;
- Name and address of at least two of the nearest OON provider(s) utilizing provider resource lists;
- Driving time/distance to at least two of the nearest OON provider(s utilizing provider resource lists;
- Number of members residing in the impacted ZIP code;
- Reasons for inability to contract with nearer providers; and
- Description of contracting efforts.

At a minimum, MCPs must utilize the following provider resource lists and identify the providers on the AAS request:

- Health Care Options.
- Fee for Service Open Data Portal.
- Office of Statewide Health Planning and Development.

DHCS approves or denies AAS requests on a ZIP code and provider type basis, including specialty type.[41] DHCS reviews the AAS request and all supporting documentation to assess the facts and circumstances provided by the MCP. The AAS request is evaluated in relation to other MCP's AAS requests for the same service area, and considers the Health Professional

[39] WIC sections 14197(e)(1)–(2).
[40] The AAS request template is available in Attachment C.
[41] WIC section 14197(e)(3).

Shortage Area (HPSA) designation of the requested service area, where applicable.[42]

MCPs must maintain documentation of their efforts to contract with nearer providers and must provide all documentation to DHCS upon request. DHCS may request additional evidence of contracting efforts if DHCS identifies more than two nearer OON providers during the review process. Following DHCS' review, DHCS will send an AAS determination letter informing MCPs of AAS approvals and denials in each service area.[43] An AAS approval is valid for one CY and must be approved every year thereafter if the MCP still needs an AAS.

2. Additional Medi-Cal Managed Care Health Plan Requirements for Approved Alternative Access Standards

MCPs that receive AAS approvals from DHCS must inform their affected members of all approved AAS through the MCP's Member Handbook and post all approved AAS, specified by county, on the MCP's internet website.[44] Each MCP must post the approved AAS on its website no later than 30 days after DHCS publishes the statewide AAS approvals on the DHCS website.[45]

MCPs that have an approved AAS for a core specialist are required to assist any requesting member in obtaining an appointment with an appropriate OON core specialist. When assisting the member, the MCP must make its best effort to establish a member-specific case agreement with an OON core specialist at the Medi-Cal fee-for-service rate or a mutually agreed upon rate. Either that, or the MCP must arrange for an appointment with an in-network specialist, unless the MCP has already attempted to establish a member-specific case agreement with the core specialist in the most recent fiscal year and the core specialist has refused to enter into an agreement.[46] The OON core specialist must be within the MCP's applicable time and distance and timely access standards and, in cases where the OON specialist is not within time and distance standards, the MCP must arrange for non-emergency medical transportation or non-medical transportation.[47]

---

[42] More information on HPSA designations is available at: https://data.hrsa.gov/tools/shortage-area/hpsa-find.
[43] WIC section 14197(e)(3).
[44] WIC section 14197.04(c).
[45] The AAS approvals are posted after the ANC submission to CMS and after CAPs are closed.
[46] WIC section 14197.04(a).
[47] WIC section 14197.04(b).

3. Telehealth

MCPs may use telehealth to meet time and distance standards if they are unable to contract with an in-person provider.[48, 49] MCPs cannot require members to access services via telehealth in place of in-person services.[50] MCPs that request to utilize a telehealth provider as an alternative access to care must submit supporting documentation and evidence of contracting efforts to DHCS for review and approval as described in Attachment B, Exhibit C-1.

If a MCP elects to utilize telehealth for compliance with time and distance standards, the telehealth services must be available to all members in the defined service area. This applies regardless of whether the member is assigned to a network provider or subcontractor, or which network provider or subcontractor the member is assigned to. MCPs may have telehealth providers that are only available to members assigned to a subcontractor as long as other members have access to telehealth services through other means. Telehealth providers and telehealth services must also meet the telehealth criteria outlined in the Medi-Cal Provider Manual and APL 19-009 (Revised): Telehealth Services Policy, including subsequent revisions to this APL.[51] In addition, telehealth providers must be certified and enrolled in the Medi-Cal program and credentialed by the MCP.[52]

Since MCPs cannot require a member to access services via telehealth, MCPs must provide transportation to a network provider within time and distance and timely access standards for medically necessary services, when requested by a member.[53]

---

[48] WIC section 14197(e)(1)(A).
[49] WIC section 14197(e)(4).
[50] WIC section 14132.72(f) is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14132.72.
[51] The Medicine: Telehealth section of the Medi-Cal Provider Manual is available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc.
[52] For more information on provider certification and enrollment, see APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment, including subsequent revisions to this APL.
[53] For more information on transportation service, see APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services, including subsequent revisions to this APL.

4. Mail Order Pharmacy

MCPs may utilize mail order pharmacies to meet time and distance standards if they make reasonable attempts to contract with a pharmacy with a physical location before utilizing a mail order pharmacy.[54] MCPs that request to use a mail order pharmacy as an alternative access to care must submit supporting documentation and evidence of all contracting efforts to DHCS for review and approval as outlined in Attachment B, Exhibit C-2.

When using mail order pharmacies, MCPs must have procedures in place to ensure that all medications are delivered in a timely manner, consistent with the member's medical need, even if medications cannot be sent through the mail, the member cannot receive medications through the mail, or the member has confidentiality concerns about receiving medications by mail.[55]

5. Delivery Structure Alternative Access Standard

In cases where an MCP is unable to meet time standards or distance standards due to its delivery structure, DHCS is authorized to determine if the MCP is capable of delivering the appropriate level of care and access to members through an AAS.[56] In order to be considered for an AAS, the MCP must provide a written request to DHCS following the instructions in Attachment B, Exhibit C-3.[57]

DHCS will provide the requesting MCP a template to submit its formal AAS justification.[58] DHCS will review all information submitted by the MCP to determine if the MCP's formal justification for AAS meets the needs of its members and ensures appropriate and timely access to care.[59] An approved AAS is valid for one CY. MCPs must submit an updated AAS justification if the MCP still requires the specified AAS at the end of the CY.

---

[54] WIC section 14197(e)(1)(A).
[55] WIC section 14185(a) is available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=5.6.
[56] WIC section 14197(e)(1)(B).
[57] WIC section 14197(e)(2).
[58] MCPs must request the AAS justification template by following the instructions in Attachment B.
[59] WIC section 14197(e)(3).

C. Annual Network Certification Submission Requirements

1. Annual Network Certification Exhibit Submission

Each MCP must submit complete and accurate ANC data and information to DHCS that reflects the MCP's network for each service area no later than 105 days before the CY begins (or the next business day if the due date occurs on a weekend or holiday). MCPs must submit all required ANC exhibits, as outlined in Attachment B and, if applicable, Attachment C, with the correct file labeling conventions through the DHCS Secure File Transfer Protocol site. MCPs that do not submit ANC exhibits by the deadline may be subject to corrective action and/or monetary sanctions. Additionally, if DHCS receives multiple revised submissions from an MCP, DHCS may not accept the submission and the MCP may be subject to corrective action and/or monetary sanctions due to non-compliance with the submission requirements specified in this APL and its attachments.

2. 274 File Submission

MCPs must upload network providers in the 274 file submission in accordance with this APL and APL 16-019: Managed Care Provider Data Reporting Requirements, including subsequent revisions to these APLs. DHCS utilizes only the most current month's 274 file submission at the time of the ANC submission to determine compliance with the MCP's contractual provider to member ratios and mandatory providers. If DHCS is unable to access the required monthly 274 file submission due to an MCP's untimely submission, a corrective action and/or monetary sanctions may be applied for data submission timeliness.

3. Certification of Documents and Data

MCPs are required to submit complete, accurate, reasonable, and timely ANC exhibits and 274 file submissions in compliance with state and federal law and this APL. MCPs must submit their certification statement on MCP letterhead by the final business day of each month to their contract manager. Repeated failure to submit this certification statement may result in the imposition of a CAP and monetary sanctions.[60]

[60] For more information, see APL 17-005: Certification of Document and Data Submissions, including subsequent revisions to this APL.

D. Annual Network Certification Validations

1. Provider Validation

DHCS validates a statistically valid sample of each MCP's network of adult and pediatric PCPs, OB/GYNs, adult and pediatric core specialists, adult and pediatric mental health outpatient providers, hospitals, and pharmacies to ensure network providers included in the MCP's 274 file submission are currently contracted with the MCP. As part of the validation process, DHCS may request signed contract pages confirming there is a current executed contract with the provider or facility.

2. Mandatory Provider Validation

DHCS validates a statistically valid sample of each MCP's network of FQHCs, RHCs, IHFs, FBCs, CNMs and LMs to ensure the mandatory providers included in the MCP's 274 file submission are currently contracted with the MCP. As part of the validation process, DHCS will review the evidence of contracting efforts and any additional documentation necessary to ensure compliance. DHCS may rescind the approval if the MCP cannot provide sufficient evidence and documentation of contracting efforts.

3. Alternative Access Standard Validation

If an MCP submits an AAS request using the templates in Attachment C, the MCP must describe all contracting efforts to support the AAS request. Through the AAS validation process, DHCS will request evidence of contracting efforts, including evidence of why the MCP was unable to contract, which must include supporting documentation as described in Attachment B, Exhibit C-4.

DHCS' AAS validation process includes a comparison of the MCP's narrative submitted through Attachment C with that of other MCPs serving the same service area and a review of the evidence on contracting efforts that support each AAS request.[61] DHCS may rescind an approved AAS if the MCP cannot provide sufficient evidence of contracting efforts.

[61] WIC Section 14197(e)(3).

II. NETWORK REQUIREMENTS FOR MEDI-CAL MANAGED CARE HEALTH PLAN SUBCONTRACTORS

MCPs are permitted to contract with network providers and subcontractors to fulfill their obligations to arrange for and deliver health care services under the MCP contracts. If an MCP delegates the responsibility to deliver Medi-Cal covered services from the MCP to a subcontractor, including but not limited to, a health plan partner, medical group, Independent Physician Association (IPA), or clinic, the subcontractor must have an adequate network that meets the requirements set forth in this APL. MCPs must allow members to access OON providers if the subcontractor does not have an adequate network. This requirement applies to any deficient network component(s), as required by state and federal law, the MCP contract, and DHCS guidance, including any applicable APLs.[62, 63]

MCPs and their subcontractors must authorize services through OON providers if the network of a subcontractor fails to meet network adequacy requirements. In doing so, members may utilize any provider in or out of the MCP's network regardless of IPA or medical group affiliation. DHCS prohibits the use of an administrative subcontractor, including but not limited to, an administrative services organization, to restrict an assigned member to a network provider's network if that network fails to meet network adequacy standards. Although DHCS certifies the aggregated MCP network, these network requirements apply.

MCPs must have contractual provisions and policies and procedures for ensuring each subcontractor has an adequate network including the use of administrative subcontractors that facilitate the referral and/or utilization management process. MCPs' contractual provisions and policies and procedures must align with DHCS' ANC process to assess the network adequacy of all subcontractors that are contracted to provide Medi-Cal covered services.

MCPs must also have contractual provisions and policies and procedures for imposing CAPs and monetary sanctions on subcontractors when they are out of compliance with network adequacy requirements. This includes timely access requirements under state and federal law, any subcontractual requirements, and or DHCS contract requirements. MCPs must report all significant instances of non-compliance to DHCS, including CAPs or monetary sanctions imposed on subcontractors.

---

[62] MCP Contract, Exhibit A, Attachment 9, Out-of-Network Providers.
[63] 42 CFR section 438.207.

MCPs must also report network provider or subcontractor non-compliance issues when those issues result in the MCP's non-compliance with contractual and legal requirements.[64] MCPs must report any significant instances of non-compliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their Managed Care Operations Division (MCOD) contract manager within three business days of discovery or imposition.[65]

III. NON-COMPLIANCE WITH NETWORK CERTIFICATION REQUIREMENTS

A. Medi-Cal Managed Care Health Plan Preliminary Findings of Non-Compliance

If an MCP's ANC submission is timely, DHCS will provide technical assistance by supplying a worksheet containing preliminary ANC findings. MCPs have two weeks to correct any findings that were caused by a reporting error and must begin to remedy findings that would result in a CAP before DHCS imposes a formal ANC CAP. MCPs may request an extension for meeting the ANC submission deadline by providing a justification, including the reason(s) why the MCP requires additional time. In the event the MCP's ANC submission is untimely, DHCS will be unable to provide technical assistance and will impose a CAP.

B. Medi-Cal Managed Care Health Plan Corrective Action Plans and Monetary Sanctions

DHCS will place MCPs who fail to meet the ANC components or rectify findings identified in the preliminary ANC findings worksheet under an ANC CAP. As part of the CAP process, MCPs must submit a plan of action detailing the steps the MCP will take to remedy the ANC deficiency findings. MCPs have six months to correct all deficiencies and must comply with all CAP mandates set forth below until DHCS closes the CAP.

Additionally, DHCS has authority to impose monetary sanctions for failure to comply with network adequacy requirements[66] DHCS will impose sanctions for not meeting the ANC components at the end of the CAP period. Finally, DHCS

---

[64] For more information on network provider or subcontractor non-compliance, see APL 16-001: Medi-Cal Provider and Subcontract Suspensions, Terminations, and Decertifications, including subsequent revisions to this APL.
[65] For more information on subcontractual non-compliance, see APL 17-004: Subcontractual Relationships and Delegation, including subsequent revisions to this APL.
[66] WIC section 14197.7.

reserves the right to impose additional sanctions on an MCP for continued failures to comply with all network adequacy requirements, CAP mandates, or the inability to correct a deficiency within the CAP timeframe.

C. Medi-Cal Managed Care Health Plan Corrective Action Plan Mandates

An MCP under an ANC CAP must comply with the following mandates:

- Authorize OON access to medically necessary providers within timely access standards and applicable time and distance standards, regardless of associated transportation or provider costs until the CAP is closed by DHCS;
- Provide status updates that demonstrate action steps the MCP is undertaking to correct the CAP deficiency(ies) bimonthly (once every two months); and
- Demonstrate its ability to effectively provide OON access information to members and ensure that its MCP member services staff, network providers, and subcontractors are trained on the mandates.

DHCS will review the bimonthly submissions and the MCP's deliverables to ensure compliance with CAP mandates and provide technical assistance if additional corrective action is required.

If an MCP submits an updated or new AAS to rectify a network deficiency, the MCP must continue to provide transportation services for members to any network providers for which it has an approved AAS and approve requested OON access until DHCS has reviewed and approved the updated or new request.

MCPs are also required to ensure network providers and subcontractors adhere to the CAP mandates and comply with OON access requirements.

IV. POST NETWORK CERTIFICATION MONITORING ACTIVITIES

A. Ongoing Monitoring

MCPs are subject to a quarterly monitoring process by DHCS that reviews additional activities, including but not limited to:

- Timely access surveys;

- Investigation of complaints, grievances, appeals, and issues of non-compliance;[67]
- A random sample of the MCP network provider annual network assessments;
- Quality of care indicators;
- Provider to member ratios; and
- OON requests.

In conjunction with the quarterly monitoring processes, DHCS continues its existing data quality review processes by verifying encounter and provider data quality. Encounter and provider data quality metrics include, but are not limited to, primary source verification that is conducted by DHCS' External Quality Review Organization (EQRO) through encounter data validation studies and provider surveys, respectively. In addition, MCPs are subject to a mandatory network adequacy validation performed by the EQRO. The EQRO will validate the previous 12 months of MCP compliance with network adequacy requirements.[68]

B. Public Reporting

DHCS posts all requested and approved AAS on its website.[69] Additionally, DHCS posts CAP reports, which include the findings of DHCS' ANC evaluation and identifies all MCPs that are under a CAP for failure to comply with network adequacy standards. The MCP's response to the CAP will be posted on the DHCS website. [70] In addition, DHCS submits an annual compliance report to CMS and makes it available on the DHCS website.[71]

C. Policies and Procedures

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures, the MCP must submit its updated policies and procedures to its MCOD contract manager within 30 days of the release of this APL. If an MCP determines that no changes to its policies and procedures are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 30 days of the release of this APL attesting that the MCP's policies and procedures have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

---

[67] WIC section 14197(f)(2).
[68] 42 CFR section 438.358(b)(1)(iv).
[69] WIC section 14197(e)(3).
[70] WIC section 14197(f)(3).
[71] 42 CFR section 438.207.

MCPs are ultimately responsible for ensuring members obtain medically necessary covered services from an OON provider if the services cannot be provided by a network provider in accordance with contractual requirements. MCPs are also required to ensure that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities, network providers and subcontractors.

If you have any questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Electronic Visit Verification (EVV) Provider Type, Procedure and Place of Service Codes

In California, for Medi-Cal (also known as Medicaid) Electronic Visit Verification (CalEVV) is a telephone and computer-based solution that electronically verifies when in-home service visits occur for Personal Care Services (PCS) and Home Health Care Services (HHCS). All EVV systems must electronically verify the following six visit data elements: (1) Type of service performed; (2) Individual receiving the service; (3) Date of the service; (4) Location of service delivery; (5) Individual providing the services; and (6) Time the service begins and ends.

The 1115 Waiver, approved by CMS on January 1, 2022, authorizes California to provide Community-Based Adult Services (CBAS) Emergency Remote Services (ERS). ERS personal care and home health care provided in the home are subject to EVV requirements and are targeted to go live end of March.

CalEVV is required for the following rendering Medi-Cal provider types (**enrolled, contracted or sub-contracted**) using the procedures codes identified below:

NOTE: DHCS may amend this document at any time as a result of federal requirements.

Glossary added on last page.

Medi-Cal Provider Type Codes	
Provider Description	**Provider Type**
AIDS Waiver Services	PT73
Employment Agency	PT64
Home and Community Based Services (HCBS) Benefit Provider	PT68
Home Health Agency	PT14
Licensed Clinical Social Worker	PT70
Licensed Vocational Nurse; Registered Nurse	PT67
Multipurpose Senior Services Program (MSSP)	PT74
Non-Profit Proprietary Agency	PT95
Occupational Therapist	PT19
Personal Care Agency	PT66
Physical Therapist	PT25
Professional Corporation	PT69
Speech Therapist	PT37

CAMCWP - Medi-Cal Waiver Program (MCWP)[1]

Procedure Code	Service Description	PCS / HHCS
G0156	MCWP Home Health Aide	HHCS
G0299	MCWP - skilled nursing/RN ea 15	HHCS
G0300	MCWP - skilled nursing/LPN ea 15 min	HHCS
S5130	MCWP Homemaker Services per 15 min	PCS

CAMSSP - Multipurpose Senior Services Program (MSSP)[2]

Procedure Code	MSSP Service Code	Unit Type	Service Description
Z8561	3.2	Day	Supplemental Personal Care
Z8562	3.2	Hour	Supplemental Personal Care
Z8563	3.2	Visit	Supplemental Personal Care
Z8574	5.1	Day	Respite In-Home
Z8575	5.1	Hour	Respite In-Home

CAIHSS - In-Home Supportive Services (IHSS)

Procedure Code	Service Description	PCS / HHCS
Z9525	IHSS Provider Personal Care Services	PCS

LEAVE BLANK

[1] MCWP Billing Codes
[2] MSSP Billing Codes

CAHCBA - Home and Community-Based Alternatives (HCBA)[3]

HCPCS Code	Service Description	Provider Type	Modifiers	PCS / HHCS
S9122	HCBA Home health aide	HHA (14)	None / TT	HHCS
S9123	HCBA Nursing care in home R	HHA (14) / HCBS RN (67)	None	HHCS
S9124	HCBA Nursing care in the home LVN	HHA (14) / HCBS LVN (67)	None / TT	HHCS
T1005	HCBA Respite Care in the Home	HHA (14) / Personal Care Agency (66) Employment Agency (64)	None	PCS
T2017	HCBA Habilitation in the Home	HHA (14) / Professional Corp (69) / Non-Profit Proprietary Agency (95) / HCBS RN (67) / HCBS Benefit Provider (68)	None	PCS/HHCS
T1019	HCBA WPCS in the Home	HHA (14) / Non-Profit Proprietary Agency (95) / Professional Corp (69) / Personal Care Agency (66) / Employment Agency (64)	None	PCS

LEAVE BLANK

[3] Home and Community Based Services Billing Codes and Rates

CAHHA - Managed Care Plan Community Supports (MCP - CS)

- All HCPCS codes use U6 modifier- Used by Managed Care in combination with HCPCS code to indicate In-Lieu of Services Homemaker Services

HCPCS Code	*HCPCS Description*	*Modifier*	*PCS / HHCS*
S5130	MCP – CS Homemaker services; 15 min	U6	PCS
S9125	MCP – CS Respite; home; per diem	U6	PCS
T1019	MCP – CS Personal Care Services; 15 min	U6	PCS
T2020	MCP – CS Day Habilitation; per diem	U6	PCS
H2014	MCP – CS Day Habilitation; per 15 min	U6	PCS

CAHHA - (California Home Health Agency)

- Managed Care Plan (MCP) Services
- Home Health Agency (HHA) Billing Codes[4]
- Fee For Service (FFS) Providers

HCPCS Code	Service Description	Revenue Code	PCS / HHCS
G0151	MCP - Hhcp-serv of pt, ea 15 min	0421 Physical Therapy Visit	HHCS
G0152	MCP - Hhcp-serv of ot, ea 15 min	0431 Occupational Therapy Visit	HHCS
G0153	MCP - Hhcp-svs of s/l path, ea 15min	0441 Speech Pathology Visit	HHCS
G0154	MCP - Hhcp-svs of rn, ea 15 min	0551 Skilled Nursing Visit	HHCS
G0155	MCP - Hhcp-svs of csw, ea 15 min	0561 Medical Social Services Visit	HHCS
G0156	MCP - Hhcp-svs of aide, ea 15 min	0571 Aide/Home Health Visit	HHCS
G0162	MCP - Hhc lpn/rn obs/asses ea 15 min	0583 Visit/Home Health/Assessment 0589 Visit/Home Health/Other	HHCS
CPT 99501	MCP - Post-Natal Assessment and follow-up care	0580 Visit/Home Health	HHCS
CPT 99502	Home visit for newborn care and assessment	0580 Visit/Home Health	HHCS
CPT 99600	Unlisted home visit service or procedure	0589 Visit/Home Health/Other	HHCS

[4] HHA Billing Codes

Individual Nurse Providers (INP) - Private Duty Nursing - Home Health Agency[5]

HCPCS Code	Services Description	Revenue Code	Modifiers Description	PCS / HHCS
G0156	MCP - Hhcp-svs of aide, ea 15 min	0572 - Home Health Aide, hourly charge	EP - Service provided as part of Medicaid EPSDT	HHCS
G0162	MCP - Hhc lpn/r obs/asses ea 15 min	0551 - Skilled nursing, per visit	EP - Service provided as part of Medicaid EPSDT	HHCS
G0299	MCP - Skilled nursing/rn ea 15 min	0551 - Skilled Nursing, per vis	EP - Service provided as part of Medicaid EPSDT	HHCS
G0300	MCP - Skilled nursing/lpn ea 1 min	0551 – Skilled nursing, per visit	EP - Service provided as part of Medicaid EPSDT	HHCS
T1002	MCP - HHA RN shared nursing up to 15 min	0551 – Skilled nursing, per visit	EP - Service provided as part of Medicaid EPSDT	HHCS
T1003	MCP - HHA Lpn/lvn shared nursing up to 15min	0551 – Skilled nursing, per visit	EP - Service provided as part of Medicaid EPSDT	HHCS

Individual Nurse Providers (INP) - Private Duty Nursing[6]

HCPCS Code	Service Description	Revenue Code	Modifiers Description	PCS or HHCS
S9123	CCS - INP - RN nursing/ per hour	0940-Other therapeutic services, general	EP-Service provided as part of Medicaid EPSDT	HHCS
S9124	CCS - INP - LPN/LVN/ per hour	0940-Other therapeutic services, general	EP-Service provided as part of Medicaid EPSDT	HHCS

[5] Private Duty Nursing FAQ
[6] Updated EPSDT Home Health Code Conversion and Billing Instructions

California Children Services (CCS) Program[7]

HCPCS Code	Service Description	Revenue Code	Modifiers Description	PCS or HHCS
G0156	CCS-HHA home health aide,ea 15 min	0572	EP	HHCS
G0162	CCS-HHA RN supervision/ ea 15 min	0551	EP	HHCS
G0299	CCS-HHA RN direct skilled/ ea 15 min	0551	EP	HHCS
G0300	CCS-HHA LPN/LVN ea 15 min	0551	EP	HHCS
T1002	CCS-HHA RN shared nursing up to15 min	0551	EP	HHCS
T1003	CCS-HHA LPN/LVN shared nursing up to 15 min	0551	EP	HHCS
S9123	CCS-INP - RN nursing/ per hour	0940	EP	HHCS
S9124	CCS-INP - LPN/LVN per hour	0940	EP	HHCS
T1030	CCS-INP - RN shared nursing	0940	EP	HHCS
T1031	CCS-INP - LPN/LVN shared nursing	0940	EP	HHCS

Department of Developmental Services (DDS) Regional Center Service Codes

Service Code	Service Name	PCS or HHCS
062	Personal Assistance	PCS
310	Respite	PCS
313	Homemaker	PCS
320	Community Living Supports	PCS
359	Home Health Aide	HHCS
361	Skilled Nursing	HHCS
372	Speech, Hearing & Language	HHCS
375	Occupational Therapy	HHCS
376	Physical Therapy	HHCS
460	Participant Directed Nursing Services	HHCS
465	Participant-Directed Respite Service, Family Member	PCS
707	Speech Pathology	HHCS
742	Licensed Vocational Nurse	HHCS
744	Registered Nurse	HHCS
772	Physical Therapy	HHCS
773	Occupational Therapy	HHCS
854	Home Health, Agency	HHCS
856	Home Health Aide	HHCS
858	Homemaker	PCS
860	Homemaker Service	PCS
862	In-Home Respite Services, Agency	PCS
864	In-Home Respite Worker	PCS
896	Supported Living Services	PCS

[7] Part 2 - Home Health Agencies/Home and Community-Based Services (HOM)

Additional Codes added to EVV

- Home Health Agency: Physical Therapy, Occupational Therapy, Speech Therapy, and Infusion Services (I/V and SQ)
- Please note- the therapy and infusion services codes are targeted to go live April of 2023.

HCPCS Code	Add Code	Service Description	PCS/HHCS
X3900	X393	MCP/FFS - PT 1 modality; 1 area; 1st 30 min	HHCS
X3902	X393	MCP/FFS - PT 1 modality; 1 area; ea addl 30 min	HHCS
X3904	X393	MCP/FFS - PT 1 proced; 1 area; 1st 30 min	HHCS
X3906	X393	MCP/FFS - PT 1 proced; 1 area; ea addl 15 min	HHCS
X3908	X393	MCP/FFS - PT Combo mod/proc; 1+ area; 1st 30 min	HHCS
X3910	X393	MCP/FFS - PT Combo mod/proc; 1+ area; ea addl 15	HHCS
X3912	X393	MCP/FFS - Hubbard tank; 1st 30 min	HHCS
X3914	X393	MCP/FFS - Hubbard tank; ea addl 15 min	HHCS
X3916	X393	MCP/FFS - H tank/pool therapy w/exer; 1st 30 min	HHCS
X3918	X393	MCP/FFS - H tank/pool therapy w/exer; addl 15 min	HHCS
X3932		MCP/FFS - PT Home; add (+)	HHCS
X3936	X393	MCP/FFS - PT Unlisted services	HHCS
X4110	X411	MCP/FFS - OT treatment; 1st 30 min	HHCS
X4112	X411	MCP/FFS - OT treatment; ea addl 15 min	HHCS
X4114		MCP/FFS - OT Home; add (+)	HHCS
X4118	X411	MCP/FFS - OT Unlisted services	HHCS
X4302		MCP/FFS - S/l therapy (group); ea patient	HHCS
X4303		MCP/FFS - S/l therapy; indiv; per hour	HHCS
X4304		MCP/FFS - S/l therapy; indiv; per 30 min	HHCS
X4306		MCP/FFS - S/l out of office call; 1st pnt at loc	HHCS
X4320		MCP/FFS - Unlisted speech therapy services	HHCS
G0088		MCP/FFS - Admin IV drug, 1st home visit	HHCS
G0089		MCP/FFS - Admin SQ drug, 1st home visit	HHCS

Community Based Adult Services (CBAS) Emergency Remote Services (ERS)[8]

- All codes are to be billed with revenue code 3103 (adult day care, medical and social, daily).
- Please note- the CBAS ERS services codes are targeted to go live March 23, 2023.

HCPCS Code	Modifiers Description	Service Description	PCS/HHCS
S5136	CR / SC	CBAS - ERS PCS in the home; per diem	PCS
Q5001	CR / SC	CBAS - ERS HHCS in the home; per diem	HHCS

[8] Community-Based Adult Services (CBAS): Billing Codes

Glossary

Abbreviation	Description
Addl	Additional
CAIHSS	California In-Home Supportive Services Agency Model (Self Directed)
CAMCWP	California 1915(c) AIDS Medi-Cal Waiver
CCS	California Children's Services
CS	Community Supports
CSW	Clinical Social Worker
Ea	Each
EPSDT	Early Periodic Screening Diagnostic and Treatment
Exer	Exercise
FFS	Fee for Service
H/Tank	Hubbard Tank
HCBA	Home and Community-Based Alternatives
HHA	Home Health Agency
HHCS	Home Health Care Services
I/V	Intravenous
Indiv	Individual
INP	Individual Nurse Provider
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MCP-CS	Managed Care Plan and Community Supports
Modifier CR	Catastrophe/disaster related (Public Emergency)
Modifier EP	Service provided as part of Medicaid EPSDT
Modifier SC	Medically necessary service or supply (Personal Emergency)
Modifier TT	Individualized service provided to more than one patient in same setting
Modifier U6	MCP-CS in combination with HCPCS code to indicate In-Lieu of Services Homemaker Services
obs/asses	Observation and Assessment
OT	Occupational Therapist
PCS	Personal Care Services
PDN	Private Duty Nursing
Pnt	Point
Proced	Procedure
PT	Physical Therapist
RN	Registered Nurse
S/L path	Speech Language Pathologist
SQ	Sub-cutaneous
SVS/serv	Services
WPCS	Waiver Personnel Care Services

State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: July 21, 2022

ALL PLAN LETTER 22-014

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ELECTRONIC VISIT VERIFICATION IMPLEMENTATION REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with direction regarding the implementation of the federally mandated Electronic Visit Verification (EVV) requirements.

BACKGROUND:
Section 12006(a) of the 21st Century Cures Act, signed into law on December 13, 2016, added section 1903(l) to the Social Security Act (the Act), which mandates states to require the use of EVV for Medicaid-funded personal care services (PCS) and home health care services (HHCS) for in-home visits by a provider.[1] EVV is required for PCS and HHCS provided under all Medicaid authorities, including the State Plan and waivers issued under sections 1905(a)(24), 1915(b), 1915(c), 1915(i), 1915(j), 1915(k), 1905(a)(7) of the Act or under section 1115.

State law also requires implementation of EVV in accordance with the Welfare and Institutions Code (WIC), section 14043.51 Assembly Bill 133 (Committee on Budget, Chapter 133, Statutes of 2021)[2] that specifically does the following:

- Authorizes the Department of Health Care Services (DHCS) to implement an EVV System as required by federal law, in collaboration with other governmental entities;
- Requires providers rendering Medi-Cal services subject to EVV to comply with EVV requirements established by DHCS and partners[3] or be subject to non-compliance actions;

[1] Section 12006(a) of the CURES Act is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051618.pdf
[2] Legislation is searchable at: https://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml
[3] As defined in WIC section 14043.51(a)(3), partners include, but are not limited to, the California Department of Social Services, the California Department of Developmental Services

- Authorizes DHCS and its partners to implement the EVV System through Provider Bulletins and Letters, such as this one; and
- Allows DHCS to recover from MCPs any or all Federal Financial Participation lost due to an MCP's non-compliance with the EVV requirements.

California implemented EVV for PCS on January 1, 2022, and is required to implement EVV for HHCS by January 1, 2023.

EVV is a federally mandated telephone and computer-based application program that electronically verifies in-home service visits. As a result, this program will aid in reducing fraud, waste, and abuse. The EVV program must verify each type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

The definition of "personal care services" is not uniform across all the authorities under which it can be covered as a Medi-Cal benefit. In general, however, it consists of services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

POLICY:
MCPs must implement EVV requirements for HHCS by January 1, 2023.
MCPs are required to implement EVV for all Medi-Cal PCS and HHCS that are delivered during in-home visits by a provider.[4] This includes, but is not limited to, PCS and HHCS delivered as part of Community-Based Adult Services (CBAS)[5], Whole Child Model and Community Supports – personal care and homemaker services, respite services, day habilitation programs – and all other HHCS programs covered under the

---

(DDS), the California Department of Public Health, the California Department of Aging, and the Office of Systems Integration. Additional information and guidance can be found on the DHCS EVV Website, available at: https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx, and the DDS EVV Website, available at: https://www.dds.ca.gov/services/evv/. State law is searchable at: https://leginfo.legislature.ca.gov/.

[4] See the CalAIM 1115 Approval Letter and Special Terms and Conditions Section 21 (CBAS-Emergency Remote Services [ERS]) and 25 (Home and Community Based Services EVV system), available at: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Approval-Letter-and-STCs.pdf. DHCS is planning to implement EVV for CBAS-ERS January 1, 2023.

[5] The 1115 Waiver, approved by the Centers of Medicare and Medicaid Services on January 1, 2022, authorizes California to provide CBAS-ERS. ERS personal care and home health care provided in the home are subject to EVV requirements. Further guidance specific to in-home CBAS-ERS will be forthcoming.

contract between DHCS and the MCPs. Implementation of EVV is only required for PCS and HHCS delivered in a member's home, including visits that begin in the community and end in the home (or vice versa).

DHCS defines a "live-in caregiver" as a caregiver that regularly remains in the recipient's home for more than 24 hours at a time, during which they are available to provide any of the authorized PCS and HHCS. Please see the List of EVV Provider Type, Procedure, and Place of Service Codes on the DHCS EVV Website to determine which providers will be impacted by EVV requirements.[6]

EXCLUSIONS:
The following services are not subject to EVV requirements:

- HHCS or PCS that do not require an in-home visit are not subject to EVV requirements.
- HHCS or PCS provided in congregate residential settings where 24-hour service is available are not subject to the EVV requirements.
- HHCS or PCS rendered by an individual living in the member's residence does not constitute an "in-home visit" and is not subject to EVV requirements.
- Any services rendered through the Program of All-Inclusive Care for the Elderly.
- HHCS or PCS that are provided to inpatients or residents of a hospital, nursing facility including skilled nursing facility or residence of nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases.
- Durable Medical Equipment is not subject to EVV requirements.

STATE EVV VENDOR:
The State of California contracted with Sandata Technologies, LLC (Sandata) to provide a state-sponsored EVV system. Sandata is providing California with an EVV system that includes the ability to capture data elements during the visit, data portals that allow providers to view and report on visit activity, and an EVV Aggregator to provide California with EVV program oversight and analytics. The EVV Aggregator will also receive data from providers that choose to use their existing EVV system, support California's Open EVV model, and provide a meaningful data and analytics dashboard. Additionally, training videos for the Aggregator and the Business Intelligence tool will be available online, which demonstrate functionality and capabilities.

MCPs are not required to use the state-contracted EVV system. However, use of the Sandata EVV system is free to MCPs, and their Subcontractors and Network Providers,

[6] The EVV Provider Type, Procedure, and Place of Service Codes is available at: https://www.dhcs.ca.gov/Documents/EVV-Provider-Types-and-Codes.pdf.

to use for capturing and transmitting required EVV data components to the EVV Aggregator. If a Knox-Keene licensed MCP chooses to contract with a different EVV vendor, the resulting administrative service agreement must be filed with the Department of Managed Health Care.

All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:

1) The type of service performed;
2) The individual receiving the service;
3) The date of the service;
4) The location of service delivery;
5) The individual providing the service; and
6) The time the service begins and ends.

All Network Providers are required to comply with the EVV requirements when rendering PCS and HHCS, subject to federal EVV requirements. MCPs must monitor their Network Providers to ensure compliance with these requirements in accordance with the established guidelines below:

- Monitor providers for compliance with the EVV requirements and CalEVV Information Notice(s), and alert DHCS to any compliance issues.
- Supply providers with technical assistance and training on EVV compliance.
- Require providers to comply with an approved corrective action plan.
- Deny payment if the provider is not complying with EVV requirements and arrange for the participants to receive services from a provider who does comply.[7]

When a Network Provider is identified as non-compliant with these requirements, the MCP must not authorize the Network Provider to perform services and/or withhold the payment. If a non-compliant Network Provider is the employee of a subcontractor, the specific Network Provider will not be able to provide Medi-Cal PCS and HHCS services.

EVV SYSTEM - PROVIDER SELF-REGISTRATION AND TRAINING:

[7] See the Center for Medicaid and CHIP Services (CMCS) EVV Informational Bulletin (May 16, 2018), available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051618.pdf. Please also note that federal guidance highlights that "nothing in section 1903(l) can be construed to limit provider selection, to constrain beneficiaries' choice of caregiver, or to impede the way care is delivered

MCPs must ensure that their applicable Network Providers and Subcontractors complete the self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator. All MCPs must require providers of Community Supports – Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs to register no later than October 19, 2022. Once registered, Network Providers and Subcontractors will gain access to extensive training and technical assistance, including self-guided learning modules and EVV system demonstrations, provided by Sandata. DHCS will allow PCS providers up to 90 calendar days from the date of this letter, or by October 19, 2022, whichever is later, to ensure the providers are registered, trained, using an EVV system and submitting EVV visit data. MCPs must ensure that their Network Provider(s) and Subcontractor(s) subject to CalEVV requirements are registered in the online self-registration portal, are trained on how to operate the solution, and capture the six data elements with each in-home visit. MCPs are expected to comply with EVV requirements for Community Supports once they have elected to offer and implemented Personal Care and Homemaker Services, Recuperative Care (Medical Respite), and Day Habilitation programs.

Information on the self-registration portal and the link can be found on the DHCS website at: https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx

ALTERNATE EVV SYSTEM:
MCPs and their Network Providers have the option to implement EVV requirements using an alternate EVV system. Any alternate EVV system must comply with all business requirements and technical specifications, including the ability to capture and transmit the required data elements to the EVV Aggregator. MCPs, their Subcontractors, and Network Providers who choose to use an alternate EVV system are required to register in the EVV self-registration portal and must participate in state-sponsored training provided by Sandata.

BILLING AND CLAIMS
All claims for PCS and HHCS services must be submitted with allowable Current Procedural Terminology or Healthcare Common Procedure Coding System codes as outlined in the Medi-Cal Provider Manual. MCPs and/or providers must also indicate the proper Place of Service Code or Revenue Code on claims and/or encounters to indicate the rendering of PCS or HHCS in a member's home.

DHCS MONITORING:
DHCS will monitor MCPs' implementation of EVV through existing data reporting mechanisms, including reviewing encounter data, and will include EVV implementation and requirements in the scope of the annual medical audit.
POLICIES AND PROCEDURES:

The requirements contained in this APL, including future updates or revisions to this APL, will necessitate changes to MCPs' Policies and Procedures (P&Ps). MCPs must submit updated P&Ps addressing all EVV requirements to their Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. The email submission to DHCS must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. All EVV requirements must be communicated by each MCP to all Subcontractors and Network Providers required to comply with EVV requirements. MCP case managers and service providers must be able to demonstrate to DHCS their compliance with the EVV requirements. If an MCP uses an alternate EVV system, it cannot require additional expenditures or effort by participants.[8] This means that participants won't be expected to pay additional fees if the participant's provider is using an alternate EVV system.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

For more information about the EVV requirements, the EVV system, or the EVV self-registration portal, please visit the DHCS EVV webpage or contact DHCS at EVV@dhcs.ca.gov.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[8] This is in line with federal guidance that suggests using multiple approaches for notifying and training individual recipients of PCS/HHCS and their families on EVV. See the EVV CMCS Information Bulletin (May 16, 2018) for more information.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: January 19, 2018

ALL PLAN LETTER 17-020 *(REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: AMERICAN INDIAN HEALTH PROGRAMS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding reimbursement for American Indian Health Programs (Exhibit A, Attachment 8 of the MCP's contract). The Department of Health Care Services (DHCS) has developed a change in policy regarding reimbursement of American Indian Health Programs providing services to Medi-Cal managed care beneficiaries. *Revised text is found in italics.*

BACKGROUND:

Under federal law, California must ensure that American Indian Health Programs are paid the applicable encounter *rate* published annually in the Federal Register by the Indian Health Service (the Office of Management and Budget (OMB) encounter *rate*), and if there is any difference between the amount paid by an MCP and the applicable OMB encounter rate, the State is required to make an additional payment pursuant to Title 42 of the United States Code (USC) Section 1396u-2(h)(2)(C)(ii)[1] and Title 42 of the Code of Federal Regulations (CFR) Sections 438.14(c)(2) and (3).[2]

Historically, the State satisfied this requirement by tracking the amounts American Indian Health Programs received from MCPs for eligible services and by making subsequent payments necessary to meet the applicable OMB encounter rate.

[1] 42 USC Section 1396u-2(h)(2)(C)(ii) is available at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1396u-2&num=0&edition=prelim

[2] 42 CFR Sections 438.14(c)(2) and (3) are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=38cdce7f77ce8077ee8d0d1b41735ffa&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_114

Under the policy change addressed in this APL, the State will now require that MCPs *make the necessary payments* to American Indian Health Programs *so that they receive the applicable OMB encounter rate* for eligible services provided on or after January 1, 2018.

POLICY:

Effective January 1, 2018, MCPs are required to *make the payments described below, so that* American Indian Health Programs for eligible services provided on or after January 1, 2018, at the applicable OMB encounter rate, published in the Federal Register by the Indian Health Service.

MCPs are reminded of their obligations to attempt to contract with American Indian Health Programs, prompt payment requirements, and the allowance for non-contracted American Indian Health Programs access, where applicable.

Office of Management and Budget Encounter Rate and Services:

Where the OMB encounter *rate applies, American Indian Health Programs must be paid as follows:*

1) *For* Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the *required payment is the difference between* the "Outpatient Per Visit Rate (Excluding Medicare)" *listed in the Federal Register and 80 percent of the Medicare Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate, as set forth in 42 USC 1395w-4(e)(6)(A)(ii). See Attachment 2 for the specific Dual rate.*

2) *For* Medi-Cal *beneficiaries that do* not have Medicare *Coverage* or *have* Medicare Part A only*, the required payment is the "Outpatient Per Visit Rate (Excluding Medicare)". See Attachment 2 for the specific Non-Dual rate.*

The service types—medical visits, ambulatory visits, and mental health visits— for which the OMB encounter *rate applies* are set forth in the California Medicaid State Plan Supplement 6, Attachment 4.19-B.[3] The service types reimbursed at the OMB

[3] The *relevant State Plan Amendment* is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement6toAttachment4.19-B-REVISEDMAY.pdf

encounter rate are further detailed in the Provider Manual.[4] To the extent that the Provider Manual conflicts with this APL, the requirements of this APL shall apply. Exceptions to MCP covered services that shall continue to be reimbursed outside the OMB encounter rate are: Non-Medical Transportation, Non-Emergency Medical Transportation, and Pharmacy.

Additionally, this policy does not extend the responsibility of the MCP to provide for eligible OMB encounter services that are outside the responsibility of the MCP currently. For example, MCPs will not be responsible for reimbursing the clinics for any dental services provided. The American Indian Health Programs will continue to follow their current billing practices for services outside the MCP's responsibility.

The OMB encounter rates are historically published with a retroactive effective date. MCPs are required to pay the most current applicable *payments as described in this APL (see Attachment 2)* during the calendar year for which the rate applies, and as an interim rate in a subsequent calendar year if an updated OMB rate has not been published. Plans shall ensure interim payments are reconciled to the applicable updated OMB rate for that calendar year in accordance with contractual prompt payment requirements.

Reimbursement Requirements:

MCPs shall ensure that the following criteria are met for receipt of *payments as described in this APL*:

- The American Indian Health Program provider must be identified by DHCS (see Attachment).
- Service must be a covered benefit included in the MCP's contract with DHCS.
- As set forth in California Medicaid State Plan Supplement 6, Attachment 4.19-B, only one OMB encounter rate payment per day, per category, shall be allowed within the following three categories. This allows for a maximum of three OMB encounter payments per day, one from each category:

[4] The Provider Manual sections related to IHS are available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/indhealth_o01o03.doc

- Medical Health Visit (Encounter) – A medical visit is a face-to-face encounter occurring at a clinic or center between a American Indian Health Program recipient and physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse in certain circumstances.

- Mental Health Visit (Encounter) – A mental health visit is a face-to-face encounter between an American Indian Health Program recipient and a psychiatrist, clinical psychologist, clinical social worker, or other health professional for therapeutic mental health services.

- Ambulatory Visit (Encounter) – An ambulatory visit is a face-to-face encounter between an American Indian Health Program recipient and a health care professional other than a physician or mid-level practitioner which is included in California's Medi-Cal State Plan.

Monitoring of Subcontractors and Delegated Entities:

MCPs remain ultimately responsible for meeting the American Indian Service Programs reimbursement requirements, and must ensure that their delegated entities and subcontractors comply with all applicable State and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance and All Plan Letters (APLs). MCPs must communicate these requirements to all delegated entities and subcontractors in a timely manner to ensure compliance.

If you have any questions regarding this APL, and/or requests for an approved list of American Indian Service Programs, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: March 16, 2023

ALL PLAN LETTER 23-005
SUPERSEDES ALL PLAN LETTER 19-010

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: REQUIREMENTS FOR COVERAGE OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES FOR MEDI-CAL MEMBERS UNDER THE AGE OF 21

PURPOSE:
The purpose of this All Plan Letter (APL) is to clarify the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible Members under the age of 21. This policy applies to all Members under the age of 21 who are enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provisions of Medi-Cal services, including EPSDT. This guidance is also intended to outline requirements for MCPs to ensure Members have access to information on EPSDT and Network Providers receive standardized training on EPSDT utilizing the newly developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit.

BACKGROUND:
In 1967, Congress expanded the Medicaid benefit for children with the creation of the EPSDT benefit. The EPSDT benefit is set forth in the Social Security Act (SSA) Section 1905(r) and Title 42 of the United States Code (USC) Section 1396d.[1, 2] The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in full-scope Medicaid. According to guidance from the Centers for Medicare and Medicaid Services (CMS), titled EPSDT —A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (June 2014) on page one, “The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health

[1] SSA Section 1905 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[2] 42 USC Section 1396d is available at: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim

care they need when they need it—the right care to the right child at the right time in the right setting."[3]

Under the EPSDT benefit, states are required to provide any Medicaid-covered service listed within the categories of mandatory and optional services in the SSA Section 1905(a), regardless of whether such services are covered under California's Medicaid State Plan, for Members who are eligible for EPSDT services when the services are determined to be Medically Necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

The SSA Section 1905(r) and Title 42 of the USC Section 1396d(r) defines EPSDT services as follows:

> (r) Early and periodic screening, diagnostic, and treatment services. The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:
> (1) Screening services—
> (A) which are provided—
> (i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and
> (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and
> (B) which shall at a minimum include—
> (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
> (ii) a comprehensive unclothed physical exam,
> (iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,

[3] EPSDT — A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents is available at: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

(iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
(v) health education (including anticipatory guidance).

(2) Vision services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—
(A) which are provided—
(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and

conditions discovered by the screening services, whether or not such services are covered under the State plan.

Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care
The Patient Protection and Affordable Care Act (ACA) specified that coverage of Preventive Care and screenings must be conducted with evidence-informed, comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), which is an agency of the United States Department of Health and Human Services. HRSA participated in the development of, and provides ongoing support to, the national health promotion and prevention initiative known as Bright Futures, which is led by the American Academy of Pediatrics (AAP). The AAP develops theory-based and evidence-based guidance and recommendations for Preventive Care screenings and well-child visits for children and regularly publishes updated tools and resources for use by clinicians and state agencies. These tools include the "Bright Futures Guidelines" and the "Recommendations for Preventive Pediatric Health Care," which is also known as the "periodicity schedule." The periodicity schedule indicates specific preventive screenings and procedures that are to be provided to children at age-specific periodic intervals from birth through age 21.[4]

EPSDT in California
For Members under age 21, MCPs must provide a more robust range of Medically Necessary services than they do for adults that include standards set forth in federal and state law specific to EPSDT. This includes the contractual obligation to provide EPSDT in accordance with the AAP/Bright Futures periodicity schedule.[5]

EPSDT is established in the Medi-Cal Schedule of Benefits set forth in Welfare and Institutions Code (WIC) Section 14132(v)[6], which states that, "Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code."[7]

---

[4] For more information about the AAP/Bright Futures initiative, and to view the most recent periodicity schedule and guidelines, go to https://brightfutures.aap.org/Pages/default.aspx. Additional information on the periodicity schedule is available at: https://www.aap.org/en-us/professional-resources/practice- transformation/managing-patients/Pages/Periodicity-Schedule.aspx
[5] MCP Contract, Exhibit A, Attachment 10, Services for Members under Twenty-One (21) Years of Age. MCP Contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[6] WIC Section 14132. State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
[7] 42 USC Chapter 7, Subchapter XIX. The USC is searchable at: https://uscode.house.gov/.

WIC Section 14059.5(b)(1)[8] states that for individuals under 21 years of age, a service is "Medically Necessary" or a "Medical Necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. WIC Section 14059.5(b)(2) requires DHCS and its contractors to update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the Medical Necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials.

POLICY:
EPSDT includes but is not limited to the specific services listed above in Title 42 of the USC Section 1396d(r). For Members under the age of 21, MCPs are required to provide and cover all Medically Necessary EPSDT services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the MCP Contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be Medically Necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

A service does not need to cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition, or those that can prevent adverse health outcomes, are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable or to make better." Additional services must be provided if determined to be Medically Necessary for an individual child.[9]

Medical Necessity decisions are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements and, thus, are not permitted. When Medically Necessary, MCPs may not impose limits on EPSDT services and must cover services listed in Section 1905(a) of the SSA regardless of whether or not they have been approved under a State Plan Amendment (SPA)

Pursuant to WIC Section 14059.5(b)(1), for individuals under 21 years of age, a service is considered "Medically Necessary" or a "Medical Necessity" if the service meets the

[8] WIC Section 14059.5. State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
[9] EPSDT — A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, pages 23 and 24, is available at: https://www.hhs.gov/guidance/document/epsdt-guide-states-coverage-medicaid-benefit-children-and-adolescents.

standards set forth in federal Medicaid law for EPSDT (Title 42 of the USC Section 1396d(r)(5)). Therefore, an EPSDT Covered Service is considered Medically Necessary or a Medical Necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions. MCPs must apply this definition when determining if a service is Medically Necessary or a Medical Necessity for any Member under the age of 21.

MCPs must use the current AAP Bright Futures periodicity schedule and guidelines when delivering care to any Member under the age of 21, including but not to health and developmental screening services, physical examination, dental services, vision services, and hearing services.[10] MCPs must provide all age-specific assessments and services required by the MCP Contract and the AAP/Bright Futures periodicity schedule. However, this does not alleviate MCPs of their responsibility to provide any Medically Necessary EPSDT services that exceed those recommended by AAP/Bright Futures.

All Members under the age of 21 must receive EPSDT preventive services, including screenings, designed to identify health and developmental issues as early as possible. MCPs must provide Members with appropriate referrals for diagnosis and treatment without delay. MCPs are also responsible for ensuring Members under the age of 21 have timely access to all Medically Necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

In addition, MCPs must comply with the Americans with Disabilities Act mandate to provide services in the most integrated setting appropriate to Members and in compliance with anti-discrimination laws.[11,12]

Behavioral Health Treatment
MCPs are responsible for providing Medically Necessary Behavioral Health Treatment (BHT) services consistent with the requirements in this APL.[13]

---

[10] MCP Contract, Exhibit A, Attachment 10, Services for Members under Twenty-One (21) Years of Age.
[11] Olmstead v. L.C. (1999) 527 U.S. 581. Decisions from the Supreme Court of the United States are available at: https://www.supremecourt.gov/
[12] California Government Code (GOV) Section 11135. GOV Section 11135 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11135.&lawCode=GOV
[13] For more information on BHT, see APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, or subsequent updates to this APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Case Management and Care Coordination, Transportation, and Member Information

Consistent with the MCP contract, MCPs must ensure the provision of Comprehensive Medical Case Management services, including coordination of care for all Medically Necessary EPSDT services delivered both within and outside the MCP's Provider Network. MCPs are also responsible for the coordination of carved-out and linked services and referral to appropriate community resources and other agencies, regardless of whether the MCP is responsible for paying for the service.[14]

MCPs must provide case management and care coordination for all Medically Necessary EPSDT services.[15] MCPs must also ensure the coverage of Targeted Case Management (TCM) services.[16] MCPs are responsible for determining whether a Member under the age of 21 meets eligibility criteria for TCM services. MCPs must also refer Members who are eligible for TCM services to a Regional Center (RC) or local governmental health program, as appropriate for the provision of TCM services. If the Member under the age of 21 is receiving TCM services, the MCP is responsible for coordinating the Member's health care with the TCM Provider, and for determining the Medical Necessity of diagnostic and treatment services that are covered under the MCP Contract that are recommended by the TCM Provider. If it is determined that a Member is not eligible for TCM services, the MCP must ensure that the Member's access to services is comparable to TCM services.

MCPs are also required to provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) to and from medical appointments for the Medically Necessary EPSDT services pursuant to their Contracts with DHCS.[17] Consistent with the requirements in APL 22-008, or subsequent updates to this APL, MCPs must provide NMT for all Medically Necessary services, including those services that are carved-out of the MCP Contract. MCPs are also required to establish procedures for Members to obtain necessary transportation services.

---

[14] MCP Contract, Exhibit A, Attachment 11, Comprehensive Case Management Including Coordination of Care Services.
[15] As defined in the MCP Contract coming into effect in 2024, Exhibit A, Attachment I, Section 1.0 Definitions and Acronyms, Care Coordination means an MCP's coordination of services for a Member between settings of care that includes: appropriate Discharge Planning for short term and long-term hospital and institutional stays, and appropriate follow up after an emergency room visit; services the Member receives from any other MCP; services the Member receives in Fee-For-Service (FFS); services the Member receives from out-of-Network Providers; and services the Member receives from community and social support Providers.
[16] MCP Contract, Exhibit A, Attachment 11, Case Management and Coordination of Care.
[17] APLs are searchable at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

MCPs must effectively inform Members under the age of 21, or their families/primary caregivers, about EPSDT, including the benefits of Preventive Care, the services available under EPSDT, where and how to obtain these services, and that necessary transportation and scheduling assistance is available. In addition to existing requirements for the provision of the Member Handbook/Evidence of Coverage to Members, this information must be provided annually to Members under age 21 or their families/primary caregivers.[18] MCPs have a responsibility to provide health education, including anticipatory guidance, to Members under age 21 and to their parents or guardians in order to effectively use those resources, including screenings and treatment.[19,20] The information provided must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in federal and state law; the MCP Contract; and APLs, including APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, and APL 18-016, Readability and Suitability of Health Education Materials, or subsequent updates to these APLs.

Certain Carved-Out Services

For Members under the age of 21, MCPs are required to provide and cover all Medically Necessary EPSDT services except those services that are specifically carved out of the MCP Contract and not included in the MCP's capitated rate. Carved-out services vary and can include, but are not limited to, California Children's Services (CCS) Program for non-Whole Child Model (WCM) counties, , pharmacy services, dental services, Specialty Mental Health Services, and Substance Use Disorder Services. This portion of the APL is not intended to address all carved-out services; however, DHCS is providing necessary clarification to MCPs below specific to the CCS Program and dental services for when these services are carved-out of the MCP Contract.

MCPs must provide NMT for all Medically Necessary services, including those services that are carved out of the MCP Contract. MCPs are responsible for coordination for NEMT.

California Children's Services Program

Some MCP Contracts carve-out coverage for CCS-eligible conditions.[21] If a Member of an MCP is under the age of 21 and the MCP Contract carves out coverage for CCS-

---

[18] Title 42 of the Code of Federal Regulations (CFR), Part 441. The CFR is searchable at: https://www.ecfr.gov/.
[19] 42 USC Section 1396d(r)(1)(B)(v)
[20] EPSDT — A Guide for State: Coverage in the Medicaid Benefit for Children and Adolescents, page 4.
[21] DHCS' Overview of CCS Medical Eligibility is available at: https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx

eligible conditions, then the Member may obtain treatment related to the CCS-eligible condition from CCS if the Member enrolls in CCS.

Once the MCP has adequate diagnostic evidence that a Member has a CCS-eligible condition, the MCP must refer the Member to the local county CCS office for determination of eligibility. Until the Member's CCS eligibility is confirmed by the local CCS Program, and the Medically Necessary services are being provided under the CCS Program, the MCP remains responsible for the provision of all Medically Necessary EPSDT services. After a Member is enrolled in the CCS Program within a Whole Child Model county, obligation of the MCP's case management and care coordination must continue to communicate with the local county CCS Program to ensure that the Member's care needs are continuously met and to arrange for the Member's EPSDT services. For those Members enrolled in an MCP within a Classic CCS county, case management and care coordination are the obligation of the local CCS county Program.

Dental Services

Although dental services are carved-out of most MCP Contracts, the Contract requires MCPs to cover and ensure that dental screenings/oral health assessments for all Members are included as a part of the Initial Health Appointment.[22,23] For Members under the age of 21, a dental screening/oral health assessment must be performed as part of every periodic assessment, with annual dental referrals made for Members no later than 12 months of age or when a referral is indicated based on assessment. Fluoride varnish, including when provided by a primary care pediatrician, and oral fluoride supplementation assessment and provision must be consistent with the AAP/Bright Futures periodicity schedule and anticipatory guidance. MCPs must also ensure that Members are referred to appropriate Medi-Cal dental Providers.

Additionally, MCPs must cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists, but may require prior authorization for medical services required in support of dental procedures.[24]

Outreach and Education Materials

In partnership with stakeholders, including Medi-Cal-enrolled children and families, DHCS developed child-focused and teen-focused brochures that provide an overview of

[22] Dental services are not carved out for the Health Plan of San Mateo Dental Pilot.
[23] For more information, see APL 22-030, Initial Health Appointment, or subsequent updates to this APL.
[24] For more information, see APL 15-012, Dental Services – Intravenous Sedation and General Anesthesia Coverage, or subsequent updates to this APL.

EPSDT, including Covered Services, how to access those services, and the importance of Preventive Care. DHCS also developed the "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter that illustrates what to do if Medi-Cal care is denied, delayed, reduced, or stopped including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources. The brochures and Your Medi-Cal Rights letter underwent extensive stakeholder review and consumer testing to ensure the materials met the needs of Members and Providers in Medi-Cal. Based on consumer feedback, DHCS is referring to EPSDT as Medi-Cal for Kids & Teens in these outreach and education materials. MCPs must use these brochures and the "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter, developed by DHCS. For consistent messaging, MCPs will be required to update their Member-facing materials as needed with "Medi-Cal for Kids & Teens."

MCPs are required to publish the DHCS materials and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter on their websites. MCPs may include the MCP logo on the DHCS supplied outreach and education brochures. MCPs cannot make any other changes to the brochures or Your Medi-Cal Rights letter.

Beginning in 2023, MCPs are required to mail these DHCS supplied outreach and education materials consisting of the age appropriate material and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter to Members under the age of 21 on an annual basis. For new Members, MCPs are required to mail the materials within seven calendar days of enrollment in the MCP. MCPs are required to mail out the first set of materials to existing Members beginning June 1, 2023. For 2023, DHCS will translate the brochures and Your Medi-Cal Rights letter into DHCS's threshold languages.

Beginning in 2024 and on an annual basis by January 1 of each calendar year, MCPs are required to mail or share electronically DHCS supplied materials for existing Members under the age of 21. [25] For new Members, MCPs are required to mail or share electronically, DHCS supplied materials within seven calendar days of enrollment in the MCP.

Provider Training

Starting in January 2024, MCPs are required to ensure all their Network Providers complete EPSDT-specific training no less than every two years.[26]

On an annual basis by February 15 of each calendar year, MCPs are required to submit to DHCS a comprehensive plan to ensure that all Network Providers receive proper

[25] For more information, see APL 19-003, Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format, or subsequent updates to this APL.
[26] For more information, see the Medi-Cal managed care Contract that will go live January 2024.

education and training regarding EPSDT. The annual comprehensive plan must include an attestation that their Provider Network is in compliance with the EPSDT training requirements and include a list of Network Providers who have completed training within the past 12 months. The annual comprehensive plan must also include how many Network Providers, serving Members under the age of 21, how many Network Providers are not in compliance, and an outline of the steps the MCP has taken to ensure Network Providers are fully compliant.

To reduce Network Providers contracted with multiple MCPs from completing duplicative trainings, MCPs have the option to share training records with other MCPs.

MCPs are required, at minimum, to use the Provider training program developed by DHCS to promote a more uniform and shared understanding of the benefit throughout the State. The training program refers to EPSDT as Medi-Cal for Kids & Teens. If MCPs choose to augment the training with additional information, then they must submit their training materials with edits highlighted to DHCS for review and approval prior to their use.

Coordinating with Other Outside Entities Responsible for Providing EPSDT Services

Where another entity, such as a Local Education Agency (LEA), RC, or local governmental health program, has overlapping responsibility for providing services to a Member under the age of 21, MCPs must do the following:

- Assess what level of EPSDT Medically Necessary services the Member requires,
- Determine what level of service (if any) is being provided by other entities, and
- Coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services, and that the Member is receiving all Medically Necessary EPSDT services in a timely manner.

MCPs have the primary responsibility to provide all Medically Necessary EPSDT services, including services which exceed the amount provided by LEAs, RCs, or local governmental health programs. However, these other entities must continue to meet their own requirements regarding provision of services. MCPs should not rely on LEA programs, RCs, CCS, local governmental health programs, or other entities as the primary provider of Medically Necessary EPSDT services.

The MCP is the primary provider of such medical services except for those services that have been expressly carved-out. MCPs are required to provide case management and

care coordination to ensure that Members under the age of 21 can access Medically Necessary EPSDT services as determined by the MCP Provider. For example, when school is not in session, MCPs must cover Medically Necessary EPSDT services that were being provided by the LEA program when school was in session.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. MCPs must communicate these EPSDT requirements to all Subcontractors and Network Providers. MCPs must ensure that all of their own policies and procedures (P&Ps), as well as the P&Ps and practices of any Subcontractors and Network Providers, comply with these EPSDT requirements and this APL.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DHCS will monitor MCPs for compliance with these requirements. Failure to comply with the requirements contained in this APL may result in a corrective action plan, and/or administrative and financial sanctions,[27] as provided for under the terms of the MCP Contracts and any applicable APL and state or federal statutes and regulations, including but not limited to Title 22 of the California Code of Regulations Sections 53350, 53352, and 53860.

[27] For more information, see APL 23-012, Enforcement Actions: Administrative and Monetary Sanctions, or subsequent updates to this APL.

If you have any questions regarding the requirements of this APL, please contact your MCOD contract manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: November 3, 2023

ALL PLAN LETTER 23-024 *(REVISED)*
SUPERSEDES ALL PLAN LETTER 22-031

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: DOULA SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for providing doula services, effective for dates of service on or after January 1, 2023. Revised text is found in *italics.*

BACKGROUND:
Per State Plan Amendment (SPA) 22-0002, doula services are provided as preventive services pursuant to Title 42 Code of Federal Regulations (CFR) Section 440.130(c) and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.[1,2] *The Department of Health Care Services (DHCS) issued a statewide standing recommendation*[3] *that all Medi-Cal members who are pregnant or were pregnant within the past year would benefit from receiving doula services from a Medi-Cal enrolled doula provider. The recommendation fulfills the federal requirement for a physician or other licensed practitioner of the health arts acting within their scope of practice to provide a written recommendation for preventive services.*

Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of Members while adhering to evidence-based best practices. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.

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 miscarriage, stillbirth, and abortion.

---

[1] The CFR is searchable and available at: https://www.ecfr.gov/.
[2] SPA information is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx.
[3] *The Recommendation for Doula Services for Pregnant and Post-Partum Medi-Cal Members is available at: https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Doula-Standing-Recommendation.pdf*

Doulas are not licensed and they do not require supervision.

Doulas also offer various types of support, including health navigation; lactation support; development of a birth plan; and linkages to community-based resources.

POLICY:

Covered Doula Services
Effective January 1, 2023, MCPs are 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.[4]

An initial recommendation for doula services includes the following authorizations:

- One initial visit.
- Up to eight additional visits that can be provided in any combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
- Up to two extended three-hour postpartum visits after the end of a pregnancy.

All visits are limited to one per day, per Member. Only one doula can bill for a visit provided to the same Member on the same day, excluding labor and delivery. One prenatal visit or one postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different doula.

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, up to two visits per pregnancy per individual provided on separate days.

If a Member requests or requires pregnancy-related services that are available through Medi-Cal, then the doula should work with the Member's Primary Care Provider (if that information is available) or work with the MCP to refer the Member to a Network

[4] Doulas should refer to the Telehealth section in Part 2 of the Provider Manual for guidance regarding providing services via telehealth for prenatal or postpartum visits, labor and delivery support, and for abortion and miscarriage support. The Medi-Cal Provider Manual, Medicine: Telehealth, is available at: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf.

Provider who is able to render the service.[5] These Medi-Cal services include, but are not limited to:

- Behavioral health services
- Belly binding after cesarean section by clinical personnel
- Clinical case coordination
- Health care services related to pregnancy, birth, and the postpartum period
- Childbirth education group classes
- Comprehensive health education including orientation, assessment, and planning (Comprehensive Perinatal Services Program services)
- Hypnotherapy (non-specialty mental health service)
- Lactation consulting, group classes, and supplies
- Nutrition services (assessment, counseling, and development of care plan)
- Transportation
- Medically appropriate Community Supports services[6]

A doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (i.e., a doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care). The visit must be face-to-face, and the assistive or supportive service must be incidental to doula services provided during the prenatal or postpartum visit. The Member cannot be billed for the assistive or supportive service.

Additionally, MCPs must provide doulas with all necessary, initial and ongoing training and resources regarding relevant MCP services and processes, including any available services through the MCP for prenatal, perinatal, and postpartum Members. This training must be provided initially when doulas are enrolled with the MCPs, as well as on an ongoing basis. Further, MCPs are required to provide technical support in the administration of doula services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by DHCS.

---

[5] If the service is included in the benefits offered through the MCP, the Provider must be in-Network unless the Provider type is unavailable. If the Provider type is unavailable, the MCP must arrange for Out-Of-Network (OON) services. If the service referral is for a benefit that is not included in those offered through the MCP, the MCP must coordinate a warm hand off with the entity responsible for the carved-out service.

[6] A list of Community Supports by Medi-Cal Managed Care plans can be found here: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf and information regarding Community Supports can be found here: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.

Member Eligibility Criteria for Doula Services
To be eligible for doula services, and be covered under Medi-Cal managed care, a beneficiary must be enrolled in an MCP and have a recommendation for doula services from a physician or other licensed practitioner of the healing arts.

- **Medi-Cal Eligibility Checks**: Doulas must verify the Member's MCP enrollment for the month of service. Doulas must contact the Member's MCP to verify eligibility.

- **Recommendation for Doula Services**: A Member would meet the criteria for a recommendation for doula services if they are pregnant, or were pregnant within the past year, and would either benefit from doula services or they request doula services. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a Member's pregnancy.

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 <u>not</u> covered under Medi-Cal or as doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services.

Documentation Requirements
Doula services require a written recommendation by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law. The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a Network Provider within the Member's MCP.

The initial recommendation can be provided through the following methods:

- Written recommendation in Member's record.
- Standing *recommendation* for doula services by MCP, physician group, or other group by a licensed Provider.
    - *The standing recommendation issued by DHCS on November 1, 2023 fulfills this requirement until the time it is rescinded or modified.*
- Standard form, such as the DHCS Medi-Cal Doula Services Recommendation, signed by a physician or other licensed practitioner that a Member can provide to the doula.[7] MCPs can develop a recommendation form that best meets the needs for the MCP and Provider.

A second recommendation is required for additional visits during the postpartum period. A recommendation for additional visits during the postpartum period cannot be established by standing order. The additional recommendation authorizes nine or fewer additional postpartum visits.

MCPs must ensure doulas document the dates, time, and duration of services provided to Members. Documentation must also reflect information on the service provided and the length of time spent with the Member that day. For example, documentation might state, "Discussed childbirth education with the Member and discussed and developed a birth plan for one hour." Documentation should be integrated into the Member's medical record and available for encounter data reporting. The doula's National Provider Identifier (NPI) number should be included in the documentation. Documentation must be accessible to the MCP and DHCS upon request.

Doula Provider Requirements and Qualifications
All doulas must be at least 18 years old, provide proof of an adult and infant Cardiopulmonary Resuscitation (i.e., CPR) certification from the American Red Cross or American Heart Association, and attest they have completed basic Health Insurance Portability and Accountability Act training. Additionally, a doula must qualify by meeting either the training or experience pathway, as described below[8]:

---

[7] The Medi-Cal Doula Services Recommendation form, is available at: https://www.dhcs.ca.gov/provgovpart/Documents/DoulaREC.pdf.

[8] Doula applicants may apply to enroll in the Medi-Cal program by submitting an electronic application through the Provider Application for Validation and Enrollment (PAVE) online enrollment portal, along with all supporting documentation. Doula applicants must gather the required documents listed above, as applicable, and attach them to the completed application in the applicable field in PAVE. The PAVE online enrollment portal is available at: https://pave.dhcs.ca.gov/sso/login.do?

Training Pathway:

- Certificate of Completion for a minimum of 16 hours of training which includes all of the following topics:
  - Lactation support
  - Childbirth education
  - Foundations on anatomy of pregnancy and childbirth
  - Nonmedical comfort measures, prenatal support, and labor support techniques
  - Developing a community resource list
- Attest that they have provided support at a minimum of three births

Experience Pathway:

- All of the following:
  - Attest that they have provided services in the capacity of a doula either a paid or volunteer capacity for at least five years. The five years of experience in the capacity as a doula must have occurred within the last seven years
  - Three written client testimonial letters or professional letters of recommendation from any of the following: 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.[9] "Enrolled doula" means a doula enrolled either through DHCS or through a MCP.

Continuing Education:
MCPs must 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
Network Providers, including those who will operate as Providers of doula services, are required to enroll as Medi-Cal Providers, consistent with APL 22-013, "Provider Credentialing/Re-Credentialing and Screening/Enrollment," or subsequent updates or any superseding APL, if there is a state-level enrollment pathway for them to do so.[10]

[9] Testimonial templates for doula applicants are available at: https://www.dhcs.ca.gov/provgovpart/pages/doula.aspx.
[10] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Billing, Claims, and Payments
MCPs must make payments in compliance with the clean claims requirements and timeframes outlined in the MCP Contract and Timely Payments APL.[11] These requirements apply to both MCPs and their Network Providers and Subcontractors. If a Member chooses to see an OON Provider for abortion services, the reimbursement rate must not be lower, and is not required to be higher, than the Medi-Cal Fee-For-Service rate, unless the OON Provider and the MCP mutually agree to a different reimbursement rate.[12]

MCPs are prohibited from establishing unreasonable or arbitrary barriers for accessing doula services. Claims for doula services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.[13] Doulas cannot double bill, as applicable, for doula services that are duplicative to services that are reimbursed through other benefits.

Access Requirements for Doula Services
As part of their Network composition, MCPs must ensure and monitor sufficient Provider Networks within their service areas, including doulas. To support an adequate doula Network, MCPs must make contracting available to both individual doulas and doula groups. MCPs must work with their Network hospitals/birthing centers to ensure there are no barriers to accessing these Providers when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth). MCPs must coordinate for OON access to doula services for their Members if an in-Network doula Provider is not available.

If the Member desires to have a doula during labor and delivery, MCPs must work with their In-Network hospitals and birthing centers to allow the doula, in addition to the support person(s), to be present.

DHCS Monitoring
DHCS will monitor MCPs' initial implementation of doula services and requirements through existing data reporting mechanisms such as Encounter Data, Grievances and Appeals, and the 274 Network Provider File. MCPs must ensure that doula services Providers have NPIs and that these NPIs are entered in the 274 Network Provider File.

---

[11] APL 23-020: Requirements for Timely Payments of Claims, is available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-020.pdf
[12] See APL 22-022 for Abortion Services. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[13] The Medi-Cal Provider Manual, Doula Services, is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/doula.pdf.

MCPs must review their contractually required policies and procedures (P&Ps) to determine if amendments are needed to comply with this APL. If the requirements contained in this APL , *including any updates or revisions to this APL*, necessitate a change in a*n* MCPs' contractually required policies and procedures (P&Ps) and MCPs must submit *its* updated P&Ps to their Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of this APL. *If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.*

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[14] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAPs), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent *iterations on this topic*. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[14] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, "Medi-Cal Managed Care Health Plan Guidance on Network Provider Status," and any subsequent updates or superseding APL on this topic.

State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: November 28, 2022

ALL PLAN LETTER 22-025

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RESPONSIBILITIES FOR ANNUAL COGNITIVE HEALTH ASSESSMENT FOR ELIGIBLE MEMBERS 65 YEARS OF AGE OR OLDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about the provision of the new annual Medi-Cal cognitive health assessment to eligible Members 65 years of age or older.

BACKGROUND:
California Senate Bill (SB) 48 (Chapter 484, Statutes of 2021) expands the Medi-Cal schedule of benefits to include an annual cognitive assessment for Medi-Cal Members who are 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare Program, subject to an appropriation by the state legislature for this purpose as of July 01, 2022.[1] The annual cognitive health assessment is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN).[2,3]

Additionally, SB 48 outlines requirements that Medi-Cal Providers must complete prior to being eligible to receive payment for conducting annual cognitive health assessments. Medi-Cal Providers must complete training as specified and approved by the Department of Health Care Services (DHCS), and use validated tools recommended by DHCS.

[1] Legislation and state law are searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml
[2] See the Centers for Medicare and Medicaid Services (CMS) Medicare Wellness Visits webpage at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
[3] AAN Guidelines on dementia and mild cognitive impairment: https://n.neurology.org/content/56/9/1143 and https://n.neurology.org/content/90/3/126

POLICY:
MCPs must cover an annual cognitive health assessment for their Members who are 65 years of age or older and who do not have Medicare coverage. Details regarding coverage of Current Procedural Terminology (CPT) code 1494F and quantity limits can be found in the Medi-Cal Provider Manual.[4] Any licensed health care professional who is enrolled as a Medi-Cal Provider, is acting within their scope of practice, and is eligible to bill Evaluation and Management (E&M) codes is eligible to conduct and bill for cognitive health assessments for Members of an MCP with whom they are contracted after completing the required training.

Provider Billing Requirements
In order to appropriately bill and receive reimbursement for conducting an annual cognitive health assessment, Providers must do all of the following:

- Complete the DHCS Dementia Care Aware cognitive health assessment training prior to conducting the brief cognitive health assessment;[5]
    - DHCS will maintain a list of Providers who have completed the training; MCPs will have access to the list.
- Administer the annual cognitive health assessment as a component of an E&M` visit including, but not limited to an office visit, consultation, or preventive medicine service (elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider);
- Document all of the following in the Member's medical records and have such records available upon request:
    - The screening tool or tools that were used (at least one cognitive assessment tool listed below is required);
    - Verification that screening results were reviewed by the Provider;
    - The results of the screening;
    - The interpretation of results; and
    - Details discussed with the Member and/or authorized representative and any appropriate actions taken in regards to screening results.
- Use allowable CPT codes as outlined in the Medi-Cal Provider Manual.

Providers must have completed the required training in order to bill and receive reimbursement. Plans are not obliged to reimburse Providers for assessments that were conducted prior to the completion of the training. Medi-Cal Rates can be found here.

[4] The Medi-Cal Provider Manual, E&M, Cognitive Health Assessment, is available here, p. 38
[5] Cognitive health assessment training is available at: https://www.dementiacareaware.org

Cognitive Assessment Tools

At least one cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- Patient assessment tools
  - General Practitioner assessment of Cognition (GPCOG)
  - Mini-Cog
- Informant tools (family members and close friends)
  - Eight-item Informant Interview to Differentiate Aging and Dementia
  - GPCOG
  - Short Informant Questionnaire on Cognitive Decline in the Elderly

MCPs should ensure their Providers are providing the appropriate necessary follow up services based on assessment scores and may include but are not limited to additional assessment or specialist referrals.

CPT 1494F is only applicable for Members 65 years of age and older with or without signs or symptoms of cognitive decline who do not have Medicare coverage. **For Members under 65 years of age who are reporting symptoms or showing signs of cognitive decline**, the MCP will continue to be required to provide medically necessary and appropriate coverage of assessments, which may include but is not limited to cognitive health assessments, appropriate treatment services, and necessary referrals, billed through established practices.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[6] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

[6] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, "Medi-Cal Managed Care Health Plan Guidance on Network Provider Status," and any subsequent APLs on this topic.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

DEMENTIA
Care Aware

Early detection. Better care.

The Cognitive Health Assessment

www.dementiacareaware.org



DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Table of Contents

Conducting the Cognitive Health Assessment: The Basics 03

Cognitive Health Assessment Screening Tools 04

What to Do After a Positive Screen 21

What to Know About Billing for the CHA 23

Conducting the Cognitive Health Assessment: The Basics

The Three Parts of the Cognitive Health Assessment

The Cognitive Health Assessment (CHA) has three parts. It was designed for patients ages 65 and older who have not already been diagnosed with mild cognitive impairment or dementia. However, it can be used with any patient showing signs and symptoms of cognitive decline regardless of age.

Part 1



Take a Brief Patient History

Take a very brief cognitive health history of the patient. This history can be:

- The response to an annual screening question (e.g., Have you or friends/family noted changes in your mental abilities?) OR
- The observation of a sign of cognitive decline by someone (e.g., a care partner reports that the patient has difficulty remembering medication changes)

Part 2



Use Screening Tools

Assess the patient directly for both cognitive and functional decline using screening tools. If the patient screens negative, use cognitive and functional screening tools with the patient's care partner, if available. Refer to the next table for a list of recommended tools.

Part 3



Document Care Partner Information

Identify a care partner and document the partner's contact information in the patient's record. Ideally, this is a health care agent who has legal authority to make decisions on behalf of the patient. Even if a patient's cognitive and functional screenings are negative, ask about the patient's support system. If the patient can't identify someone, then document this instead.

Cognitive Health Assessment Screening Tools

For the CHA you need to screen for both cognitive and functional impairment. There are multiple screening tools you can use to check for cognitive and functional decline, and they can be administered to the patient or the care partner. The table below lists several recommended, validated tools.

	Administered to the patient:	Administered to the care partner:
Cognitive Screening Tools	GP-COG: Part 1: General Practitioner assessment of Cognition (for the patient) Mini-Cog	Short IQ-CODE: Short Informant Questionnaire on Cognitive Decline in the Elderly AD-8: Eight-Item Informant Interview to Differentiate Aging and Dementia
Functional Screening Tools	ADLs/IADLs: Activities of Daily Living and Instrumental Activities of Daily Living	GP-COG Part 2: General Practitioner Assessment of Cognition (for the informant) FAQ: Functional Activities Questionnaire

Links to Resources

Dementia Care Aware website
General Practitioner Assessment of Cognition (GP-COG)
Mini-Cog
Short Informant Questionnaire on Cognitive Decline in the Elderly (Short IQ-CODE)
Eight-Item Informant Interview to Differentiate Aging and Dementia (AD-8)
Functional Activities Questionnaire (FAQ)

Patient name: _____

Testing date: _____

GPCOG

STEP 1 – PATIENT EXAMINATION

Unless specified, each question should only be asked once.

Name and address for subsequent recall test

I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington. (Allow a maximum of 4 attempts.)

		Correct	Incorrect
Time orientation			
1.	*What is the date?* (exact only)	☐	☐
Clock drawing (use blank page)			
2.	*Please mark in all the numbers to indicate the hours of a clock.* (correct spacing required)	☐	☐
3.	*Please mark in hands to show 10 minutes past eleven o'clock.* (11.10)	☐	☐
Information			
4.	*Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, e.g. "war", "lot of rain", ask for details. Only specific answer scores.)	☐	☐
Recall			
5.	*What was the name and address I asked you to remember?*		
	John	☐	☐
	Brown	☐	☐
	42	☐	☐
	West (St)	☐	☐
	Kensington	☐	☐
Add the number of items answered correctly:	**Total score:**	☐	**out of 9**

9	**No significant cognitive impairment** Further testing is not necessary
5 – 8	**More information required** Proceed with informant interview in step 2 on next page
0 – 4	**Cognitive impairment is indicated** Conduct standard investigations

© University of New South Wales as represented by the Dementia Collaborative Research Centre – Assessment and Better Care; Brodaty et al, *JAGS* 2002; 50:530-534

Patient name: _____

Testing date: _____

GPCOG

STEP 2: INFORMANT INTERVIEW

Informant name: _____

Relationship to patient, i.e. informant is the patient's: _____

Ask the informant:

Compared to 5–10 years ago,	YES	NO	Don't know	N/A
1. *Does the patient have more trouble remembering things that have happened recently than s/he used to?*	☐	☐	☐	
2. *Does s/he have more trouble recalling conversations a few days later?*	☐	☐	☐	
3. *When speaking, does s/he have more difficulty in finding the right word or tend to use the wrong words more often?*	☐	☐	☐	
4. *Is s/he less able to manage money and financial affairs (e.g. paying bills and budgeting)?*	☐	☐	☐	☐
5. *Is s/he less able to manage his or her medication independently?*	☐	☐	☐	☐
6. *Does s/he need more assistance with transport (either private or public)?* (If the patient has difficulties only due to physical problems, e.g. bad leg, tick 'no'.)	☐	☐	☐	☐

Add the number of items answered with 'NO', 'Don't know' or 'N/A':

Total score: ☐ **out of 6**

4 – 6	**No significant cognitive impairment** Further testing is not necessary
0 – 3	**Cognitive impairment is indicated** Conduct standard investigations

When referring to a specialist, mention the individual scores for the two GPCOG test steps:

STEP 1	**Patient examination:**	__ / 9
STEP 2	**Informant interview:**	__ / 6 or **N/A**

© University of New South Wales as represented by the Dementia Collaborative Research Centre – Assessment and Better Care;
Brodaty et al, *JAGS* 2002; 50:530-534

Mini-Cog©

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: _____ Person's Answers: _____ _____ _____

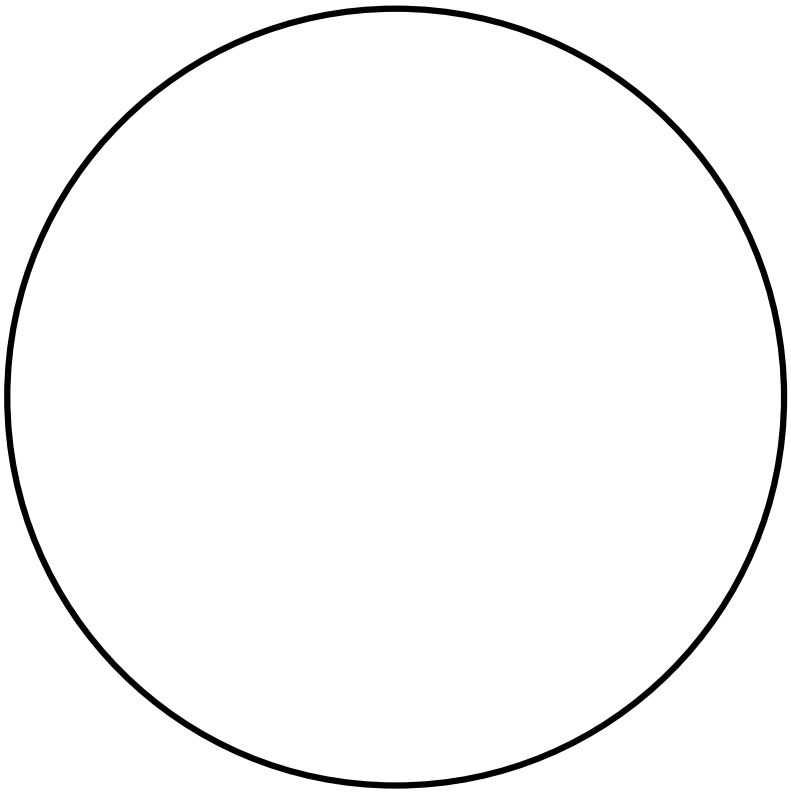
Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Mini-Cog © S. Borson. All rights reserved. Reprinted with permission of the author solely for clinical and educational purposes.
May not be modified or used for commercial, marketing, or research purposes without permission of the author (soob@uw.edu).
v. 01.19.16

Clock Drawing

ID:_____ Date:_____



References

1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population based sample. J Am Geriatr Soc 2003;51:1451–1454.
2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.
3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.
4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.
5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.
6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.
7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

Mini-Cog © S. Borson. All rights reserved. Reprinted with permission of the author solely for clinical and educational purposes. May not be modified or used for commercial, marketing, or research purposes without permission of the author (soob@uw.edu).
v. 01.19.16

AD8 Dementia Screening Interview

Patient ID#:_____
CS ID#:_____
Date:_____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	**YES, A change**	**NO, No change**	**N/A, Don't know**
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. **Daily** problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

Copyright 2005. The AD8 is a copyrighted instrument of the Alzheimer's Disease Research Center, Washington University, St. Louis, Missouri. All Rights Reserved.

The AD8 Administration and Scoring Guidelines

A spontaneous self-correction is allowed for all responses without counting as an error.

The questions are given to the respondent on a clipboard for self–administration or can be read aloud to the respondent either in person or over the phone. It is preferable to administer the AD8 to an informant, if available. If an informant is not available, the AD8 may be administered to the patient.

When administered to an informant, specifically ask the respondent to rate change in the patient.

When administered to the patient, specifically ask the patient to rate changes in his/her ability for each of the items, ***without*** attributing causality.

If read aloud to the respondent, it is important for the clinician to carefully read the phrase as worded and give emphasis to note changes due to cognitive problems (not physical problems). There should be a one second delay between individual items.

No timeframe for change is required.

The final score is a sum of the number items marked "Yes, A change".

Interpretation of the AD8 (Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564)

A screening test in itself is insufficient to diagnose a dementing disorder. The AD8 is, however, quite sensitive to detecting early cognitive changes associated many common dementing illness including Alzheimer disease, vascular dementia, Lewy body dementia and frontotemporal dementia.

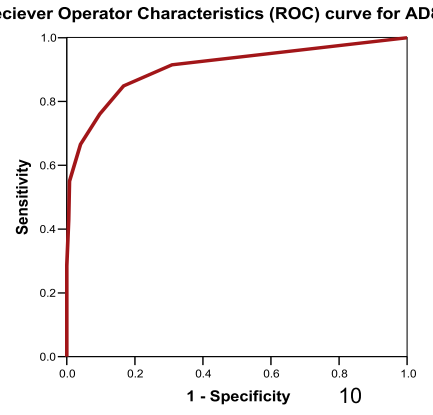
Scores in the impaired range (see below) indicate a need for further assessment. Scores in the "normal" range suggest that a dementing disorder is unlikely, but a very early disease process cannot be ruled out. More advanced assessment may be warranted in cases where other objective evidence of impairment exists.

Based on clinical research findings from 995 individuals included in the development and validation samples, the following cut points are provided:

- 0 – 1: Normal cognition
- 2 or greater: Cognitive impairment is likely to be present

Administered to either the informant (preferable) or the patient, the AD8 has the following properties:

- Sensitivity > 84%
- Specificity > 80%
- Positive Predictive Value > 85%
- Negative Predictive Value > 70%
- Area under the Curve: 0.908; 95%CI: 0.888-0.925



Copyright 2005. The *Eight-item Informant Interview to Differentiate Aging and Dementia* is a copyrighted instrument of Washington University, St. Louis, Missouri. All Rights Reserved.

Permission Statement

Washington University grants permission to use and reproduce the *Eight-item Informant Interview to Differentiate Aging and Dementia* exactly as it appears in the PDF available here without modification or editing of any kind solely for end user use in investigating dementia in clinical care or research in clinical care or research (the "Purpose"). For the avoidance of doubt, the Purpose does not include the (i) sale, distribution or transfer of the *Eight-item Informant Interview to Differentiate Aging and Dementia* or copies thereof for any consideration or commercial value; (ii) the creation of any derivative works, including translations; and/or (iii) use of the *Eight-item Informant Interview to Differentiate Aging and Dementia* as a marketing tool for the sale of any drug. All copies of the AD8 shall include the following notice: "Reprinted with permission. Copyright 2005. The *Eight-item Informant Interview to Differentiate Aging and Dementia* is a copyrighted instrument of Washington University, St. Louis, Missouri. All Rights Reserved." Please contact morrisj@abraxas.wustl.edu for use of the *Eight-item Informant Interview to Differentiate Aging and Dementia* for any other intended purpose.

Short Form of the Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE)[1]

by A. F. Jorm

Centre for Mental Health Research
The Australian National University
Canberra, Australia

There is no copyright on the Short IQCODE. However, the author appreciates being kept informed of research projects which make use of it.

Note: As used in published studies, the IQCODE was preceded by questions to the informant on the subject's sociodemographic characteristics and physical health.

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now. 10 years ago was in 20__.* Below are situations where this person has to use his/her memory or intelligence and we want you to indicate whether this has improved, stayed the same or got worse in that situation over the past 10 years. Note the importance of comparing his/her present performance with 10 years ago. So if 10 years ago this person always forgot where he/she had left things, and he/she still does, then this would be considered "Hasn't changed much". Please indicate the changes you have observed by circling the appropriate answer.

Compared with 10 years ago how is this person at:

	1	2	3	4	5
1. Remembering things about family and friends e.g. occupations, birthdays, addresses	Much improved	A bit improved	Not much change	A bit worse	Much worse
2. Remembering things that have happened recently	Much improved	A bit improved	Not much change	A bit worse	Much worse
3. Recalling conversations a few days later	Much improved	A bit improved	Not much change	A bit worse	Much worse
4. Remembering his/her address and telephone number	Much improved	A bit improved	Not much change	A bit worse	Much worse
5. Remembering what day and month it is	Much improved	A bit improved	Not much change	A bit worse	Much worse
6. Remembering where things are usually kept	Much improved	A bit improved	Not much change	A bit worse	Much worse
7. Remembering where to find things which have been put in a different place from usual	Much improved	A bit improved	Not much change	A bit worse	Much worse
8. Knowing how to work familiar machines around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse

9. Learning to use a new gadget or machine around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
10. Learning new things in general	Much improved	A bit improved	Not much change	A bit worse	Much worse
11. Following a story in a book or on TV	Much improved	A bit improved	Not much change	A bit worse	Much worse
12. Making decisions on everyday matters	Much improved	A bit improved	Not much change	A bit worse	Much worse
13. Handling money for shopping	Much improved	A bit improved	Not much change	A bit worse	Much worse
14. Handling financial matters e.g. the pension, dealing with the bank	Much improved	A bit improved	Not much change	A bit worse	Much worse
15. Handling other everyday arithmetic problems e.g. knowing how much food to buy, knowing how long between visits from family or friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
16. Using his/her intelligence to understand what's going on and to reason things through	Much improved	A bit improved	Not much change	A bit worse	Much worse

*The original tool was published in 1994.

The Alzheimer's Association updated the year 19__ as published in the original tool to 20__ .

Tool Reference: Jorm AF. A short form of the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE): development and cross-validation. Psychol Med 1994; 24: 145–153.

dementia series

try this:®

Best Practices in Nursing Care to Older Adults with dementia

alzheimer's association

From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, and the Alzheimer's Association

Issue Number D13, Revised 2016

Editor-in-Chief: Sherry A. Greenberg, PhD, RN, GNP-BC
New York University Rory Meyers College of Nursing

Use of the Functional Activities Questionnaire in Older Adults with Dementia

By: Ann M. Mayo, DNSc, RN, FAAN
Hahn School of Nursing & Health Science, University of San Diego

WHY: Dementia is a neurodegenerative disease where functional ability in individuals with dementia (IWD) declines over time. The majority of care costs in IWD are directly attributed to functional disability (Hurd, 2013). Compromised functional ability is unsafe for IWD, anxiety provoking for families and costly to health care organizations. Valid and reliable clinical information about functional ability can be used to individualize care and design safe and supportive environments thereby promoting the highest level of independence for individuals with dementia. Therefore, an effective and efficient method for measuring functional ability is important.

BEST TOOL: The Functional Activities Questionnaire (FAQ) measures instrumental activities of daily living (IADLs), such as preparing balanced meals and managing personal finances. Since functional changes are noted earlier in the dementia process with IADLs that require a higher cognitive ability compared to basic activities of daily living (ADLs) (Hall, 2011; Peres et al., 2008), this tool is useful to monitor these functional changes over time. The FAQ may be used to differentiate those with mild cognitive impairment and mild Alzheimer's disease. To further exemplify the importance and utilization of the FAQ, thousands of research participants across the United States are administered the FAQ annually as part of the National Alzheimer's Coordinating Center (NACC) longitudinal research study taking place in 29 National Institute on Aging-funded Alzheimer's Disease Centers (Weintraub et al., 2009).

TARGET POPULATION: Older adults with normal cognition, mild cognitive impairment, as well as mild, moderate, and advanced dementia (Weintraub et al., 2009). The FAQ is appropriate for clinical settings, such as acute and primary care, rehabilitation, assisted living, and home settings, as well as for research.

VALIDITY AND RELIABILITY: In IWD the FAQ is a consistently accurate instrument with good sensitivity (85%) to identify an individual's functional impairment. The FAQ demonstrates high reliability (exceeding 0.90). Tests of validity have been performed on the FAQ establishing it as an instrument for the bedside and research because it can discriminate among different functional levels of individuals, predict neurological exam ratings and mental status scores such as the Folstein Mini-Mental Status Examination (MMSE) and demonstrate sensitivity to change (Assis, 2014; Malek-Ahmadi, 2015; Pfeffer, 1982).

STRENGTHS AND LIMITATIONS: The FAQ is efficient to administer to older adults giving consistent results across different professionals and settings including primary care settings, as well as with different forms of dementia (Mayo, 2013; Tabert et al., 2002). As with other instruments that measure functional activities using indirect approaches, there may be over or under estimation of abilities because of the lack of direct observations.

FOLLOW-UP: Continued monitoring of IADLs in IWD is important to ensure environmental adaptations keeping these individuals safe. The measurement of IADLs is also important for advancing science. Therefore, the FAQ is an important measure for clinicians and researchers.

Permission is hereby granted to reproduce, post, download, and/or distribute, this material in its entirety only for not-for-profit educational purposes only, provided that The Hartford Institute for Geriatric Nursing, New York University, Rory Meyers College of Nursing is cited as the source. This material may be downloaded and/or distributed in electronic format, including PDA format. Available on the internet at www.hign.org and/or www.ConsultGeri.org. E-mail notification of usage to: hartford.ign@nyu.edu.

MORE ON THE TOPIC:
Best practice information on care of older adults: http://consultgeri.org/.
de Oliveira, Assis, L., de Paula, J., Assis, M. G., de Moraes, E. N., & Malloy-Dinis, L. F. (2014). *Frontiers in Aging Neuroscience, 5*(255), 1-7. doi: 10.3389/fnagi.2014.00255
Hall, J. R., Vo, H. T., Johnson, L. A., Barber, R. C., & O'Bryant, S. E. (2011). The link between cognitive measures and ADLs and IADL functioning in mild Alzheimer's: What has gender got to do with it? *International Journal of Alzheimer's Disease, 2011*, Article ID 276734. doi:10.4061/2011/276734
Hurd, M. D., Martorell, P., Delavande, A., Mullen, K.J., & Langa, K. M. (2013). Monetary costs of dementia in the United States. *NEJM, 368*(14),1326–1334. doi:10.1056/NEJMsa1204629.
Malek-Ahmadi, M., Chen, K., Davis, K., Belden, C. M., Powell, J., Jacobson, S. A., & Sabbagh, M. N. (2015). *Alzheimer's Research & Therapy, 7*(1), 2-9. doi: 10.1186/s13195-014-0092-z
Mayo, A. M., Wallhagen, M., Cooper, B., Mehta, K., Ross, L., & Miller, B. (2013). Functional and mental status provide insight into judgment and problem solving among patients with dementia. *International Journal of Geriatric Psychiatry, 28*(5), 514–521.
Peres, K., Helmer, C., Amieva, H., Orgogozo, J., Rouch, I., Dartigues, J., & Barberger-Gateau, P. (2008). Natural history of decline in instrumental activities of daily living performance over the 10 years preceding the clinical diagnosis of dementia: A prospective population-based study. *JAGS, 56*(1), 37-44.
Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. *Journal of Gerontology, 37*(3), 323-329.
Weintraub, S., Salmon, D., Mercaldo, N., Ferris, S., Graff-Radford, N.R., Chui, H., & et al. (2009). The Alzheimer's Disease Centers' Uniform Data Set (UDS): The neuropsychologic test battery. *Alzheimer's Disease and Associated Disorders, 23*(2), 91-101.

Functional Activities Questionnaire

Administration

Ask informant to rate patient's ability using the following scoring system:

- Dependent = 3
- Requires assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

1.	Writing checks, paying bills, balancing checkbook	
2.	Assembling tax records, business affairs, or papers	
3.	Shopping alone for clothes, household necessities, or groceries	
4.	Playing a game of skill, working on a hobby	
5.	Heating water, making a cup of coffee, turning off stove after use	
6.	Preparing a balanced meal	
7.	Keeping track of current events	
8.	Paying attention to, understanding, discussing TV, book, magazine	
9.	Remembering appointments, family occasions, holidays, medications	
10.	Traveling out of neighborhood, driving, arranging to take buses	
	TOTAL SCORE:	

Evaluation

Sum scores (range 0-30). Cut-point of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.

Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. *Journal of Gerontology, 37*(3), 323-329. Reprinted with permission of Oxford University Press.

UCSF University of California San Francisco

DEMENTIA Care Aware

ADL / IADL Checklist

You can assess a patient's functional abilities by asking about their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). ADLs are activities in which people engage on a day-to-day basis. IADLs are activities related to independent living. ADLs are basic personal care activities related to maintaining hygiene and health. IADLs are higher-level activities that enable a person to live independently in the community.

Use the following checklists to check the level of function relating to each activity.

ADL Checklist

ADL Function	Independent	Needs Help
Bathing		
Dressing		
Transferring, e.g., from bed to chair		
Toileting		
Grooming		
Feeding oneself		

IADL Checklist

ADL Function	Independent	Needs Help
Using the telephone		
Preparing meals		
Managing household finances		
Taking medications		
Doing laundry		
Doing housework		
Shopping		
Managing transportation		

COGNITIVE HEALTH ASSESSMENT SCREEN

Patient sticker/medical record barcode

Patient Name: _____ Date: _____ Translator Present? ___ Y ___N

1. DOCUMENT CARE PARTNER: Is there someone that helps you make decisions about your health and medical care?

FULL NAME: _____PHONE:_____

2. TAKE A BRIEF HISTORY

Do you or others think that you are having trouble remembering things? Check all that apply. ___ Y ___N ___Not Sure

3A. ADMINISTER MINI-COG **Total: _____/5 points**

COGNITIVE SCREEN ABNORMAL (<3/5)? ___Yes ___No

THREE-WORD RECALL (STEP 1):

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to step 2 (clock drawing).

___*List 1*: Banana, Sunrise, Chair ___*List 2*: Leader, Season, Table ___*List 3*: Village, Kitchen, Baby

CLOCK DRAW (STEP 2): **Score: _____/ 2 points (0 or 2)**

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11." Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to step 3 if the clock is not complete within three minutes.

Clock Draw Scoring:
*2 points for a normal clock or 0 (zero) points for an abnormal clock drawing.
*A normal clock must include all numbers (1-12), each only once, in the correct order and direction (clockwise).
*There must also be two hands present, one pointing to the 11 and one pointing to 2.

If the patient states that they are not able to draw the clock, say "I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute." (Repeat instructions if necessary). Maximum score for this item is 14. If person names 14 unique animals in less than one minute there is no need to continue.

(≥ 14 unique animals, score 2 points. Fewer than 14 unique animals, score 0 points.)

THREE-WORD RECALL (STEP 3): **Score: _____/3 points**

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the person's answers below.

Person's Answers: _____ _____ _____

3B. ADMINISTER FUNCTIONAL SCREEN

ACTIVITIES OF DAILY LIVING *if not completed on Senior Health Screen **Score:_____/6 points**

Must be independent. No supervision, direction, or personal assistance (1 point each)

____ Bathing ____ Dressing ____ Toileting ____ Transferring ____ Continence ____ Feeding

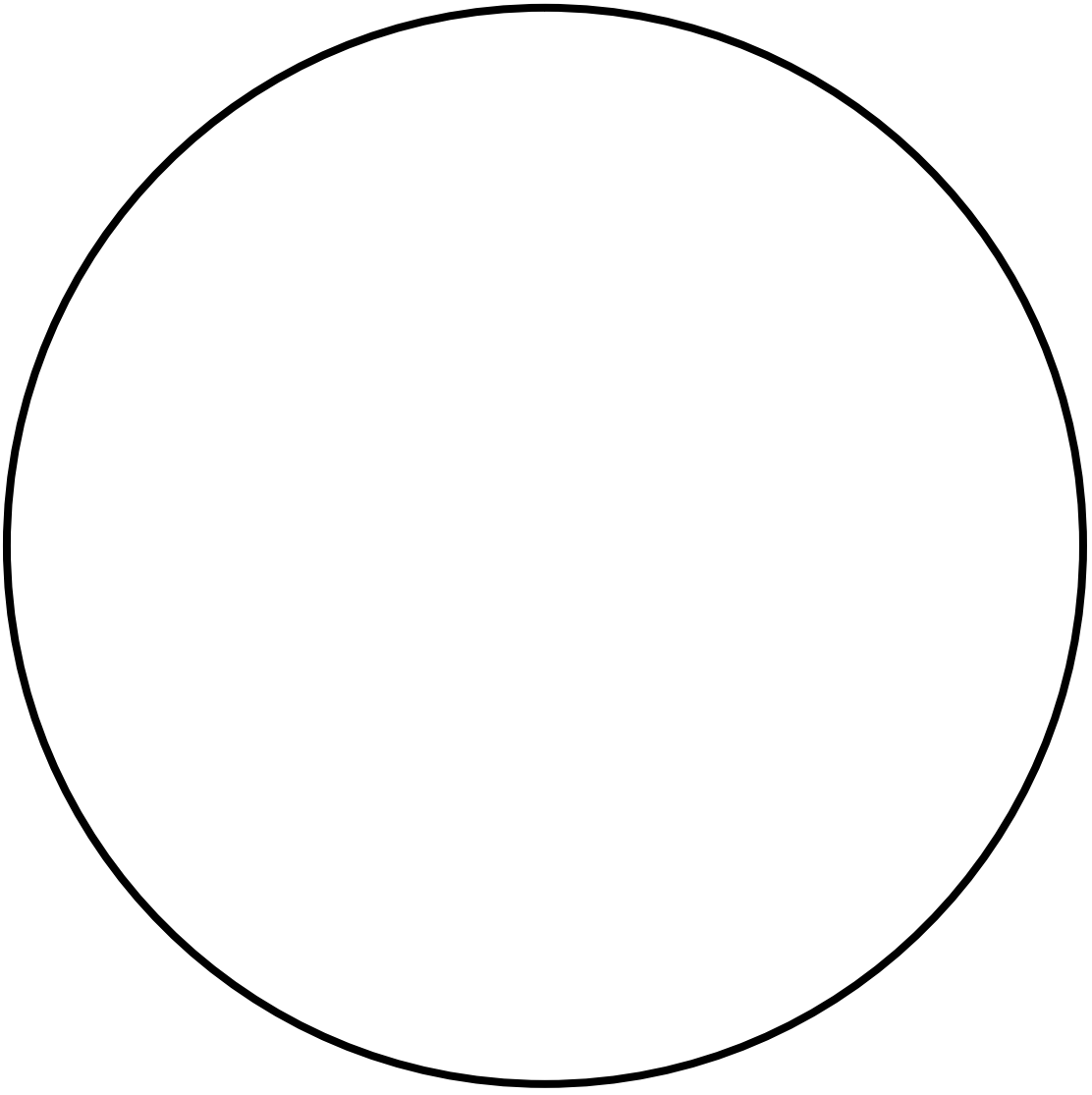
INSTRUMENTAL ACTIVITIES OF DAILY LIVING *if not completed on Senior Health Screen **Score: _____/8 points**

Must be independent. No supervision, direction, or personal assistance (1 point each)

____ Answers Phone ____ Shopping ____ Food prep/cook ____ Housekeeping (participates)

____ Transportation ____ Medication management ____ Finances (includes day-to-day purchases) ____ Laundry

Patient sticker/medical record barcode



Patient sticker/medical record barcode

3C.ADMINISTER INFORMANT SCREEN

AD8 DEMENTIA SCREENING INTERVIEW **Score: _____/8 points**

Give to a family member or care partner to fill out if available.

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, a change	NO, no change	NA don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4.Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

What to Do After a Positive Screen

The CHA is an initial screening process to detect signs of cognitive decline. The CHA is not a diagnostic tool. If the CHA is positive, next steps involve additional assessments to determine if the decline is due to mild cognitive impairment or dementia. Here is a recommended framework for next steps:

Cognition

If the CHA comes back positive:

- Screen for depression and substance use
- Evaluate for other diseases with cognitive symptoms (e.g., HIV, syphilis, thyroid disorders, obstructive sleep apnea, vitamin B12 deficiency)
- Order labs and head imaging if less than 12 months of symptoms (CBC, electrolytes, BUN/Cr, fasting glucose)
- A more detailed cognitive symptom history is also recommended to identify whether referral to a specialist is warranted.

Function

Based on the results of the functional assessment, consider connecting patients to services based on their needs, such as:

In-Home Supportive Services to obtain a caregiver

Money management services

Meal delivery services

Legal services for access to benefits through Medi-Cal and other programs

Support System

Document the roles and contact information for the patient's support system:

- The care partner for the CHA screen
- Support persons or additional care partners
- Health care agent(s) or durable power of attorneys

Connect the patient's support system to needed services such as legal services for advance care planning.

Start a Brain Health Plan

You can start a brain health plan to maximize brain function in all older adults, but it will especially benefit those with cognitive or functional decline. You can also start the plan before any diagnosis of mild cognitive impairment or dementia is made. A brain health plan consists of the following:

- Make sure vision and hearing assessments are up to date and, if impairments are present, correct them accordingly.
- Review medications for cognitive side effects and reduce as many of these as you can in dose or frequency, and preferably stop them.
- Encourage social and physical activity.
- Continue to address blood pressure and diabetes management goals.



What to Know About Billing for the CHA

Effective July 1, 2022, an annual CHA for Medi-Cal only beneficiaries who are 65 years of age or older is a covered benefit if the beneficiary is otherwise ineligible for a similar assessment as part of an annual wellness visit under the Medicare program (for more information on billing for Medicare patients, visit our website). A provider also must be registered as having completed the core Cognitive Health Assessment training, available on the Dementia Care Aware website. This assessment should be a component of an Evaluation and Management (E&M) visit. When a CHA is performed, bill an additional claim line using **CPT-4 code 1494F Cognition assessed and reviewed.**

Note: For patients under 65 years of age who are reporting symptoms or showing signs of cognitive decline, the provider should do a CHA and then may bill Medi-Cal using normal Evaluation and Management (E&M) codes.



Providers must complete the course Conducting the CHA: The Basics before they can begin billing for the CHA.



Qualifying CHA screenings are eligible for payment in any clinical setting in which billing occurs through Medi-Cal fee-for-service or to a network provider of a Medi-Cal-managed care plan.

The rate is $29 and is limited to once per year, per same provider.



The reimbursement rate depends upon a provider's contract with the patient's **Medi-Cal managed care** plan.



Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will be reimbursed for this service as part of the Prospective Payment System (PPS) process.

Required Billing Documentation for Medi-Cal Only Beneficiaries

Required documentation only emphasizes the results of the cognitive screen, though we recommend you complete all portions of the CHA. All documentation must remain in the patient's medical record and be available upon request. Billing can occur for 1494F if the provider documents:

1. The screening tool or tools that were used (at least one cognitive screening tool is required to bill this code)
2. That the completed assessments were reviewed by the provider
3. The results of the assessment(s)
4. The interpretation of the results
5. That the results were discussed with the patient, family, or informant, and any appropriate actions were taken

Example of the required documentation:

I reviewed the patient's cognitive health assessment. She scored 1 point on the Mini-Cog, which is abnormal. I disclosed this result to the patient and plan to send for hearing and vision tests, as well as schedule a follow-up for further assessment and care planning at the next visit.

SUBJECT: **ECP Policies and Procedures** **Policy #:** PR.5
DEPARTMENT: Provider Services Department

Effective Date: January 1, 2026

SCOPE: Policy applies to Medi-Cal, Medicare, Medi-Medi and Commercial/Covered CA Programs.

PURPOSE:

Policy and procedure explaining the process of recruiting/loading/activating new Essential Community Providers to meet network adequacy requirements. ECPs include a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111-8; or a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act, or an Indian health care provider, unless any of the above providers has lost its status under either of these sections, 340(B) of the PHS Act or 1927 of the Act as a result of violating Federal law.

POLICY:

The IPA will maintain an adequate number and geographic distribution of essential community providers (ECPs), to ensure reasonable and timely access to ECP providers for low-income individuals or individuals residing in the IPA's areas in accordance with the health networks adequacy standards. ECP facilities include but are not limited to: Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers, Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, and Rural Emergency Hospitals (reference 45 C.F.R. §156.235)

PROCEDURE:

A. **RECRUITMENT**

1. When the provider services department is notified of a ECP inadequacy or request for ECP recruitment, the provider services representative will reach out to the corresponding ECP with a recruit cover letter, formal contract, Ancillary CPPA Application and required credentialing criteria. The provider services representative will document the ECP on their "Recruit Tracking Log" and will maintain proper follow-up with the ECP facility via email/phone/mail etc. to ensure the contract is signed to meet network adequacy.

B. **CREDENTIALING**

2. Once the contract and credentialing documents are received, the provider service representative will forward the documents with a checklist to the credentialing

department, identifying them as a ECP provider.

C. **NEW PROVIDER ORIENTATION FORMS**

3. Upon the Credentialing Committee's approval of a new ECP's Ancillary credentialing application, a "Welcome" letter will be sent to the facility along with a copy of the executed Agreement with the IPA and a "Physician Office Manual - Quick Reference Sheet

4. Provider Services Representative will review with physician, Office Manager and office staff the processes and requirements under the following areas of operations:

    a. Eligibility & Enrollment

    b. Member Services

    c. Utilization Management

    d. Case Management

    e. Claims

    f. Provider Services & Contracting

    g. Credentialing

    h. Quality Management

5. In addition, the Provider Services Representative will provide forms that the offices are required to make available to members, staff and physicians:

a. Member Grievance & Appeals Form

b. Provider Grievance & Appeals Form

c. IPA Complaint, Grievance & Appeals Process

d. Health Plan Grievance & Appeal Process

e. State Fair Hearing Process

f. Department of Corporations Grievance & Appeal Process

g. Initial Health Assessment Forms

h. Access and Availability requirements.

6. At the conclusion of the in-service, the Provider Services Representative will obtain the physician's signature on the "New Provider In-Service Acknowledgement Form" indicating receipt of the Provider Manual and all applicable forms. A "New Provider In-Service Evaluation" survey will also be provided to the physician to obtain feedback regarding the quality of the training.

D. **LOADING/FLAGGING ECP in database**:

7. Upon notification of the physician's approved status, the Provider Services Representative will load the ECP facility into our database, identifying them as the appropriate ECP facility under the specialty field (i.e. federally qualified health center etc)

E. **HEALTH NETWORK NOTIFICATION**

8. The provider services representative will forward the completed ECP profile to the health network with corresponding required forms to ensure network deficiency is closed.

REFERENCES: 45 C.F.R. §156.235

Medi-Cal for Kids & Teens Provider Training

Medi-Cal for
Kids and Teens

January 2026

Today's Training

- **Goals & Purpose of Today's Training**
- **Training Modules**
  - **Module 1:** What is Medi-Cal for Kids & Teens and How Does it Work?
  - **Module 2:** Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

Federal law enacted in 1967 established **Early and Periodic Screening, Diagnostic and Treatment (EPSDT),** which guarantees all medically necessary services to children and youth under age 21 enrolled in Medi-Cal. As of 2023, California refers to EPSDT as

Medi-Cal for Kids & Teens

Millions of Children in Medi-Cal Are Not Receiving Preventative Health Services

In 2019, the California State Auditor released a report highlighting the low rates of children's preventative health services in Medi-Cal. A follow-up audit in 2022 underscored that millions of Medi-Cal-enrolled children are still not receiving preventative services. In response, the Department of Health Care Services (DHCS) committed to developing a standardized provider training on Medi-Cal for Kids & Teens.

The 2019 California State Audit found:

- 2.4 million children enrolled in Medi-Cal did not receive required preventive services – roughly half of all children under age 21 in Medi-Cal
- Pre-pandemic, California ranked 40th nationwide for utilization of children's preventive services, or 10 percentage points below the national average

Since the COVID-19 pandemic, California's preventive services utilization has continued to decline:

1 in 2 children ages 12 – 21 received at least one annual well-care visit



22% of children under the age of 3 received a developmental screening



Less than half of children at age 13 were fully immunized



Goals of Medi-Cal for Kids & Teens Provider Training

The training aims to strengthen understanding and awareness of Medi-Cal for Kids & Teens among Medi-Cal managed care plan-enrolled providers and increase access to children's health services.



- California's managed care plans must ensure that all Medi- Cal licensed providers receive proper education and training regarding Medi-Cal for Kids & Teens at least every two years.
- More information on Medi-Cal for Kids & Teens for providers is available in the Information for Medi-Cal Providers resource document.

Medi-Cal for Kids & Teens Training Modules

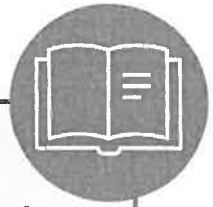


Module 1: What is Medi-Cal for Kids & Teens and How Does it Work?



Module 2: Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

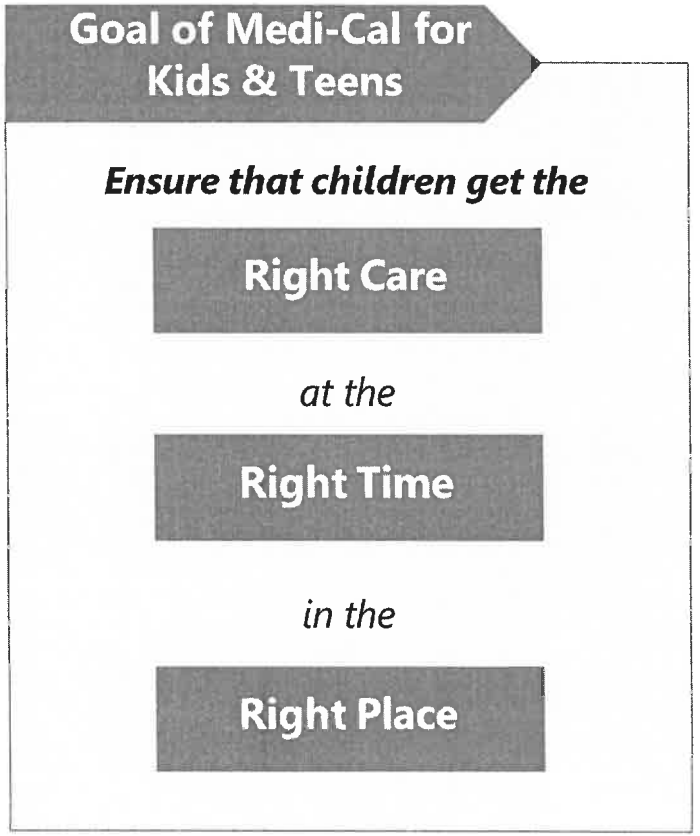
In This Module You Will Learn:



- What is Medi-Cal for Kids & Teens
- What screening, diagnostic services, and treatment services are covered under Medi-Cal for Kids & Teens
- What the definition of "medical necessity" means for children enrolled in Medi-Cal
- What limitations can be placed on Medi-Cal for Kids & Teens services
- How you can help support access to required services for your patients
- Your role in informing children and families about Medi-Cal for Kids & Teens covered services

What is Medi-Cal for Kids & Teens?

- Requires comprehensive age-appropriate health care service be provided to all Medi-Cal enrolled children and you under age 21
- Requires preventative screening, diagnostic services, and treatment services
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than that for adults' care



Medi-Cal for Kids & Teens Services Are Free for Most Children Under Age 21



- All medically necessary Medi-Cal for Kids & Teens preventative, screening, diagnostic, and treatment services for children and you are free for most children and youth under age 21
- Some youth between ages 18 and 20 enrolled in Medi-Cal may pay a "Share of Cost" for some treatment based on their income and family size. This is determined at the time of Medi-Cal eligibility. These youth are "carved out" of Medi-Cal managed care and receive services through fee-for-service.

Medi-Cal for Kids & Teens Periodicity Schedule

- Medi-Cal for Kids & Teens follows the **Bright Futures/American Academy of Pediatrics (BF/AAP) Periodicity Schedule.**
- The BF/AAP Periodicity Schedule is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.
- The most up to date BF/AAP Periodicity Schedule can be accessed online here.



Medi-Cal for Kids & Teens Periodic Screenings

Medi-Cal for Kids & Teens screening services are designed to identify health and developmental issues as early as possible.

Reimbursable Screening Services

Comprehensive health and developmental history	Comprehensive, unclothed physical exam, including nutritional, height/weight, and Body Mass Index assessment	Behavioral health screening, including depression screening and tobacco, alcohol, or drug use
Developmental screening for physical and mental health using standardized screening tools	Age-appropriate immunizations (based on the Bright Futures / American Academy of Pediatrics (BF/AAP) Periodicity Schedule and Advisory Committee on Immunization Practices (ACIP) Recommendations)	Age-appropriate laboratory tests, including blood lead screening test
Oral health screenings and referrals to a dentist (beginning by age 1 or eruption of first tooth)	Age-appropriate vision and hearing screenings	Health education and anticipatory guidance for child and caregiver



Any qualified Medi-Cal provider (acting within the scope of their practice) may conduct these screenings.

Screenings may be provided at physician offices and clinics, community health centers, local health departments, or schools



Families do not need to request these screenings, and prior authorizations are not permitted

Module 1 Module 2

Medi-Cal for Kids & Teens Screenings & Services

The following slides outline requirements for a subset of required screenings and services, including screening tools and billing codes.

Subset of Required Medi-Cal for Kids & Teens Screenings & Services	
Blood Lead Screening Services	Vision Screening Services
Developmental Screening Services	Hearing Screening Services
Autism Spectrum Disorder (ASD) Screening Services	Oral Health Screening Services
Depression Screening Services (for adolescents and postpartum individuals)	Adverse Childhood Experiences (ACEs)/Trauma Screening Services
Dyadic Services	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Blood Lead Screening Services (1 of 2)

Providers must perform blood lead screening tests at specific intervals and deliver anticipatory guidance to parents/caregivers that indicates children can be harmed by exposure to lead and are at risk of lead poisoning.

Anticipatory Guidance. Providers must provide oral or written anticipatory guidance to parents or caregivers at each well-child visit starting at 6 months until 6 years of age; guidance must include information on:

- The harm of lead exposure to children (especially from lead-based paint and its dust) **and**
- The risk of lead poisoning from the time a child begins to crawl until 6 years of age

Periodicity Schedule. Providers must order or perform blood lead screening tests for children at the following intervals:

- At 12 months and 24 months of age;
- In between 12 to 24 months of age if the child has no documented evidence of a blood lead screening test taken;
- In between 24 months to 6 years of age if the child has no documented evidence of a blood lead screening test taken;
- Any time a change in circumstances has put the child at risk; **or**
- If requested by the parent or caregiver

Blood Lead Screening Services (2 of 2)

Refugee Screening. Providers must follow the CDC Recommendations for Post-Arrival Lead Screening of Refugees, which states that all refugee children ages 0-16 or adolescents over age 16 with suspected lead exposure should be evaluated with a blood lead screening test

Lead Screening CPT Codes

- The following CPT codes may be used in the context of blood lead screening and counseling:
  - 36415 – Collection of venous blood by venipuncture
  - 36416 – Collection of capillary blood specimen (e.g. finger, heel ear stick)
  - 83655 – Blood lead analysis

Optional Counseling Codes (use with caution):

- 99401- 99404 – Preventative medicine counseling (15-60 minutes)

These codes are not billable in conjunction with preventative health visit codes (e.g. 99381-99385). Their use should be limited to standalone counseling visits where lead exposure is the primary focus.

Note: Providers should follow Medi-Cal billing guidance and APL 20-016 for documentation and reporting requirements. Utilization of 99401-99404 for lead counseling is not required for compliance but may be used when appropriate.

See California Department of Public Health's (CDPH) Standard of Care Guidelines on Childhood Lead Poisoning for California Health Care Providers for more information

Developmental Screening Services

Providers must deliver developmental screenings at age-appropriate intervals at ages 9 months, 18 months, and 30 months per BF/AAP Periodicity Schedule, and when medically indicated.

- **Overview.** The developmental screening includes a comprehensive health and developmental history, including both physical and mental health development assessments, designed to identify if a child's motor, language, cognitive, social, and emotional development are on track and connect to services, if needed
  - **Billing Codes.** The CPT code for reimbursement is 96110; screenings can be provided twice a year for children ages 0 to 5
  - **Screening Tools.** Providers must use a standardized screening tool, with approved options including:
    - Ages and Stages Questionnaire (ASQ)
    - Ages and Stages Questionnaire (ASQ-3)
    - Battelle Developmental Inventory Screening Tool (BDI-ST)
    - Bayley Infant Neuro-developmental Screen (BINS)
    - Brigance Screens-II
    - Child Development Inventory (CDI)
    - Infant Development
    - Parents' Evaluation of Developmental Status (PEDS)
    - Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- **Referrals to Regional Centers.** Providers should refer children to Regional Centers for services and supports that are needed because of a developmental disability



Supplemental Incentive Payment. Under Proposition 56, Medi-Cal reimburses providers a supplemental incentive payment of $59.90 for developmental screenings

Autism Spectrum Disorder Screening Services

Providers must perform autism spectrum disorder (ASD) screenings at 18 and 24 months, per the BF/AAP Periodicity Schedule, and when medically indicated.

- **Billing Codes.** Providers should use the developmental screening CPT code 96110 but must include the modifier KX
  - ASD and developmental screenings are reimbursable when performed on the same day at 18 months and when medically indicated
- **Screening Tool.** Providers must use a validated screening tool to screen for ASD, such as: MCHAT-R/F (ages 16 to 30 months old); SCQ (ages 4 years old and up); and STAT (ages 24 to 35 months old)
- **Services & Referrals.** Medi-Cal for Kids & Teens covers all medically necessary behavioral health treatment for eligible enrollees under 21 years of age regardless of ASD diagnosis
  - Behavioral health treatment services include applied behavioral analysis (ABA) and a variety of other evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction, and promote, and functioning
  - Providers should refer individuals to either their managed care plan or their local Regional Center to receive medically necessary behavioral health treatment services



Examples of behavioral health treatment services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

Depression Screening Services



Depression Screening

- **Periodicity Schedule.** Providers must perform **depression screenings on children** ages 12 and older at every well-child visit
- **Billing Codes.** The HCPCS codes are G8431 (positive screening with follow-up plan) and G8510 (negative screening and no follow-up plan) may not be submitted more than once a year per child unless to correct or ameliorate a condition (see slides 27-29). Apply modifier EP for EPSDT services.



Postpartum Depression Screening at Infant Visits

- **Periodicity Schedule.** Providers may perform postpartum depression screenings **for the birthing parent** at up to four times during an infant's first year of life
  - BF/AAP Periodicity Schedule recommends this happens during the well-infant visits at 1, 2, 4, and 6 months of age
  - **Billing Processes.** These screenings must be billed to the infant's Medi-Cal ID regardless if the birthing parent is enrolled in Medi-Cal; if the infant's Medi-Cal eligibility has not been established during the first two months of life, the screening may be billed to the birthing parent's Medi-Cal ID
- **Billing Codes.** Providers must submit at least one claim with a diagnosis code if multiple depression screenings are performed for a single Medi-Cal member with HCPCS codes G8431 and G8510 in a year.

Screening Tools. Providers must use a validated depression screening tool for children and youth and pregnant or postpartum individuals, with options including the Patient Health Questionnaire (PHQ-9), Edinburgh Postnatal Depression Scale (EPDS), and Beck Depression Inventory (BDI)

Dyadic Services

As of January 2023, Medi-Cal covers dyadic and family therapy services, which include integrated physical and behavioral health screenings and services for the child and their parent/caregiver or whole family, not just the child who is the identified patient. Dyadic services involve simultaneous treatment for the child and parent/caregiver, with studies showing significant improvements in child behavior issues and increases in positive parent/child attachment.



Dyadic Services for Children ages 0 to 20

Billing Codes. Medi-Cal reimburses a number of dyadic services for recipients ages 0 to 20 years, when billed to the child's Medi-Cal ID. The U1 modifier is required to designate dyadic services.

- Dyadic Behavioral Health (DBH) Well-Child Visits (H1011)
- Dyadic Comprehensive Community Support Services (H2015)
- Dyadic Psychoeducational Services (H2027)
- Dyadic Family Training and Counseling for Child Development (T1027)

Dyadic Services for Parent/Caregivers Billing Codes.

Providers may also deliver dyadic caregiver services at a well child visit in which the caregiver(s) are present. The U1 modifier is required to designate dyadic services.

- Brief emotional/behavioral assessment (96127)
- ACE screening (G9919, G9920)
- SABIRT (G0442, H0049, H0050)
- Depression screening (G8431, G8510)
- Health behavior assessments and interventions (96156, 96167, 96168, 96170 and 96171)
- Psychiatric diagnostic evaluation (90791, 90792)
- Tobacco cessation counseling (99406, 99407)

See the Non-Specialty Mental Health Services Manual for more information on dyadic services **billing codes, modifiers, and screenings**

Vision and Hearing Screening Services

Providers must deliver vision and hearing screening for all children and youth under age 21 per BF/AAP Periodicity Schedule to identify need for glasses, contacts, hearing aids, cochlear implants, or other concerns.

Vision Screening

- **Periodicity Schedule.** Providers must conduct vision screenings at years 3, 4, 5, 6, 8, 10, 12, and 15, with risk assessments conducted at other ages
- **Screening Tools.**
  - Providers may use instrument-based screening to assess risk at ages 12 and 24 months and at well child visits at ages 3 through 5 years
  - Providers may deliver a visual acuity screening starting at ages 4 and 5 years, as well as in cooperative 3-year-olds
- **Billing Codes.** Reimbursement codes include CPT 99173*, 99381 thru 99385 and 99391 thru 99395

*For school-based enrolled Medi-Cal providers only

Hearing Screening

- **Periodicity Schedule.**
  - Providers must confirm the initial newborn screening was completed, verify results, and follow up as appropriate
  - After the newborn screening, providers must conduct hearing screenings at years 4, 8, 10, 13, 16, and 20, with risk assessments conducted at other ages
- **Billing Codes.** Reimbursement codes include CPT 92551 (screening test, pure tone, air only) and 92552 (pure tone audiometry [threshold]; air only) with ICD-10-CM diagnosis codes Z00.121, Z00.129, Z01.10, or Z01.11 available for hearing screenings

Module 1 | Module 2

Oral Health Screening & Assessment Services

Providers must perform oral health screening and assessment services and ensure children ages 6 years and under are referred to a Medi-Cal Dental provider. Primary care providers have an important role in ensuring oral health care, guidance, and education are provided to children and families.

- **Oral Health Screening Schedule.**
  - Primary care providers must conduct an oral health assessment at minimum at the 6, 9, 12, 18, 24, and 30 month well-child visits, as well as annually starting at age 3 and up *or* sooner at eruption of first tooth, should that occur first
  - On this same schedule, primary care providers must assess whether the child has a dental home. If no dental home is identified, then providers must refer the child to a Medi-Cal dental provider
- **Billing Codes.** Reimbursement codes CPT 99381 – 99383 and 99391 – 99393 for oral health risk assessment
- **Fluoride Varnish.** Once teeth are present, fluoride varnish should be applied to all children every 3 – 6 months through age 5 in the primary care or dental office based on caries risk
  - Reimbursement codes HCPCS D1206 and CPT 99188 for fluoride varnish, up to three times in 12-month period
- **Fluoride Supplementation.** If a child's primary water source does not contain fluoride, primary care providers must consider providing fluoride supplementation to children ages 6 months through 16 years of age



Dental providers are responsible for providing dental care that goes beyond oral health assessments (such as dental cleanings and tooth extractions). Medi-Cal managed care providers are responsible for providing referrals to a dental provider in the child's network, which will either be Dental Fee For Services (in most California counties) or Dental Managed Care (in Sacramento and Los Angeles Counties).

ACEs/Trauma Screening Services

Providers may conduct adverse childhood experiences (ACEs) screenings for all children and youth under age 21. ACEs screenings are not currently included in the BF/AAP Periodicity Schedule but are encouraged through the California Surgeon General's _____ campaign and are reimbursable.

- **Recommended Schedule.** Providers may conduct ACEs screenings once per year, per child
  - ACEs "scores" are designated as high risk for toxic stress if a child's ACEs score is 4 or greater (HCPCS G9919) or low risk for toxic stress if the ACEs score is between 0 and 3 (HCPCS G9920)
- **Screening Tool.** Providers must use the validated PEARLS screening tool for ages 0 – 19 years for ACEs screening
- **Provider Training.** Providers must complete and attest to having completed the ACEs Aware Training in order to be eligible to receive the incentive payment (see box below)
- **Referrals.** Providers who conduct ACEs screenings must provide children with appropriate referrals when necessary for diagnosis and treatment without delay

Supplemental Incentive Payment. Under Proposition 56, Medi-Cal reimburses providers *who completed and attested to the ACES Aware training* with a supplemental incentive payment of $29.00 for trauma screenings

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Providers must provide SABIRT screening and services to children ages 11 years and older with a potential substance use disorder (SUD).

- **Screening.**
  - Validated screening tools for children/adolescents: Parents, Partner, Past, and Present (4Ps) and Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
  - **Billing Codes.** Reimbursement codes HCPCS G0442 for alcohol use screening and H0049 for drug use screening
    - If using CRAFFT, which is for alcohol and drug use screening, providers can bill both G0442 and H0049
- **Brief Assessment.** If a screening is positive, then providers should assess whether the disorder is present.
  - Validated assessment tools: Drug Abuse Screening Test (DAST-20) and Alcohol Use Disorders Identification Test (AUDIT)
- **Brief Interventions & Referral to Treatment.** If a brief assessment reveals alcohol or drug misuse, providers can conduct brief interventions, which can include alcohol misuse counseling and discussing and agreeing on plans for follow-up, including referral to other treatment if indicated.
  - **Billing Codes.** Reimbursement code HCPCS H0050 for alcohol and/or drug brief intervention services
- **Provider Type.** SABIRT services are reimbursable to physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists, and licensed marriage and family therapists
- **Documentation Requirements.** The provider must include in the child's medical records:
  - The service provided (e.g., screen and brief intervention);
  - The name of the screening and/or assessment tool and scores; and
  - If a referral to an alcohol or SUD program was made

Initial Health Appointment

Previously called the "Initial Health Assessment (IHA)," the Initial Health Appointment (IHA) is a Medi-Cal managed care requirement for adults and children to ensure new members receive a comprehensive assessment by a primary care provider.

- The IHA consists of a history of the member's physical and behavioral health, identification of risks, assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases
- Providers must conduct the IHA within **120 days of a child's enrollment** in a managed care plan (or within the BF/AAP Periodicity Schedule timeline for children ages 18 months or younger, **whichever is sooner**)
  - If the first 120 days of a child's enrollment in a managed care plan falls within the timing of a child's scheduled well-child visit according to the BF/AAP Periodicity Schedule, the child's well-child visit will serve as the IHA
  - IHA cannot be delayed beyond the first 120 days of a child's initial enrollment in order to coincide with a scheduled well-child visit according to the BF/AAP Periodicity Schedule that is later than 120 days from enrollment; an earlier, separate IHA will be indicated in this case
- Each managed care plans' processes and policies are different, but managed care plans should support providers in helping to schedule an appointment to conduct the IHA within the required time period

As Needed Screenings (1 of 2)

While regular (periodic) screenings are required, additional screenings must be done any time when medically necessary to assess diagnoses between regularly scheduled screenings. These as needed screenings are called "interperiodic screenings."



- As needed screenings **may not** be limited in number nor require prior authorization
- Medical necessity of as needed screenings may be determined by the child's physician; dentist; or a health, developmental, or educational professional who comes into contact with the child
- A parent or caregiver can request a child receive an as needed screening outside of the BF/AAP Periodicity Schedule
- As needed screenings should be billed using the appropriate preventive medicine CPT code and ICD-10 CM diagnosis code Z00.8 (encounter for other general examination); the reason for the as needed screening must be documented in the medical record

As Needed Screenings (2 of 2)

Examples of As Needed Screenings (not limited to):



A child receiving **foster care** receives a medical history and physical examination



A child joining a **sports** team or camp receives a pre-participation medical history and physical examination



A child with a history of **perinatal problems** receives additional screenings



A child enrolling in **school** receives a pre-participation medical history and physical examination



A child with a history of **developmental disability** receives additional screenings



A child or their parent/caregiver or guidance receives additional **anticipatory guidance**



A child entering California as a **refugee** receives a medical history and physical examination

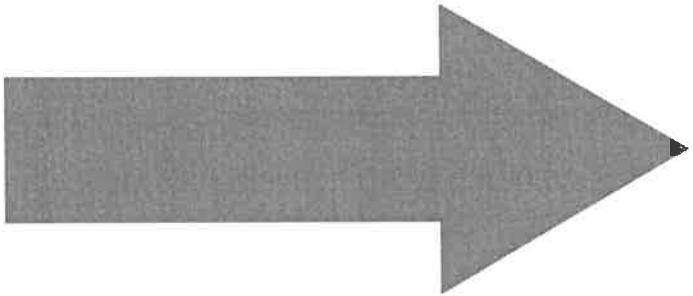
Medi-Cal for Kids & Teens
Diagnostic Services



Screening Services

Screenings are designed to identify health and developmental issues as early as possible

When diagnostic and/or treatment services are indicated as a result of a screening, providers must take all reasonable steps, including follow-up, to ensure enrollees receive medically necessary diagnostics and treatment **no later than 60 days after screening**





Diagnostic Services

A child's diagnosis may be provided by a physician or other qualified practitioner

Medical Necessity (1 of 2)

» Medi-Cal for Kids & Teens **defines medical necessity broader for children and youth enrolled in Medi-Cal compared to adults.** If a service is medically necessary and is included within any of the mandatory or optional categories of Medicaid-covered services listed in Section 1905(a) of the Social Security Act, then it must be provided to the child, even if the service is not included in the Medi-Cal State Plan.

» Under Medi-Cal for Kids & Teens, medical necessity is defined under federal and state requirements as services **correcting or ameliorating conditions, defects, and physical and mental illnesses.**

» **A service need not cure a condition** in order to be covered under Medi-Cal for Kids & Teens. Services that **maintain (by preventing a condition from worsening or preventing additional health problems) or improve a child's condition** are covered because they **"ameliorate"** a condition.

Medical Necessity (2 of 2)

» Medical necessity must be **determined on a case-by-case, individual basis** and **consider all aspects of the child's needs**

» Providers play a significant role in medical necessity determinations, as they are responsible for **justifying why a service is medically necessary for a child** to their contracted managed care plan

» DHCS and its managed care plans **may require prior authorization** in order to safeguard against unnecessary use of services

- Prior authorization **cannot delay or deny** medically necessary services
- Limits based on a monetary cap or budgetary constraints **may not be imposed**; for example, if it is medically necessary for a child to have 20 hours per week of private duty nursing, then the managed care plan cannot limit the service to 10 hours per week

» California's managed care plans **may not use a definition of medical necessity that is more restrictive** than the federal definition, which is the same definition as in California law

Medical Necessity Review Criteria

What is a medically necessary service per Medi-Cal for Kids & Teens?

Medically Necessary	Not Medically Necessary
✓ Service is reasonable, appropriate, and effective method to correct, maintain, or ameliorate the child's medical needs ✓ Service is in accordance with current medical standards or practices ✓ Service's scope (e.g., number of hours of skilled nursing care) is sufficient to address the child's needs ✓ Service is necessary to ensure for a safe environment for the child to ameliorate a given condition	✓ Service is experimental or investigational (considered on a case-by-case basis) ✓ Service is primarily for caregiver convenience (e.g., DME duplicated to be provided at divorced parents' homes) ✓ Service is more expensive than an equally effective and less expensive, available service; however, cost is not a basis for determining a service should not be provided



If the service is determined to be medically necessary, the service must be covered if it can be covered under Medicaid, even if it is not in the Medi-Cal State Plan or not provided to adults, or if the child does not have a diagnosis

Second Opinions



- If a provider requests a service for a child that is **denied** by the managed care plan, then the provider can request a **second opinion** from a qualified health professional
- Managed care plans must permit second opinions through their **Utilization Management Program** that ensures appropriate processes are used to review and approve the provision of medically necessary covered services in Medi-Cal Managed Care

Medical Necessity Review Criteria: Occupational Therapy Example



- An 8-year-old enrolled in a Medi-Cal managed care plan receives a periodic developmental screening at their well-child checkup that indicates a developmental delay
- The pediatrician prescribes the child occupational therapy services
- The pediatrician submits a prior authorization request for occupational therapy to the Medi-Cal managed care plan
- The managed care plan conducts medical necessity review and determines the occupational therapy services are **not** medically necessary
- The pediatrician requests a second opinion through the managed care plan's Utilization Management Program with another qualified health professional
- The other qualified health professional agrees with the pediatrician's assessment that the therapy is medically necessary for the child and submits results to the managed care plan
- The managed care plan reviews the second opinion and determines the occupational therapy services are medically necessary
- The pediatrician refers the child to a licensed occupational therapist and provides follow-up care

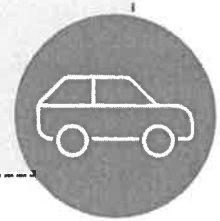
Settings for Medi-Cal for Kids & Teens Services: School-Based Services

- Medi-Cal-enrolled children and youth under age 21 can receive the following Medi-Cal covered services from schools:
  - Nutritional assessments and counseling treatments
  - Vision assessments and screenings
  - Physical, respiratory, occupational, and speech- language therapy
  - Audiology assessment, treatments, and hearing screening tests
  - Psychology and counseling services and psychosocial assessments
  - Orientation and mobility services
  - Developmental assessments
  - Specialized medical transportation
  - Health education and anticipatory guidance
  - School health aide services (administration of specialized physical health care services and assistance with Activities of Daily Living)



Settings for Medi-Cal for Kids & Teens Services: Out-Of-State Services

- DHCS and its managed care plans must cover out-of-state services if the service would be covered in-state, and:
  - Service is required because of an emergency;
  - The child is out of state and the child's health would be endangered if they were required to travel to their home state;
  - Service is more readily available in another state; **or**
  - The child lives in an area that often utilizes services in another state (i.e., if area borders another state)



Settings for Medi-Cal for Kids & Teens Services: Telehealth Modality

- Medi-Cal covered benefits or services may be provided via telehealth if:
  - The treating provider believes the benefits or services are clinically appropriate to deliver via telehealth;
  - Benefits or services meet procedural definition and components of CPT or HCPCS codes and Medi- Cal provider manual guidelines; **and**
  - Benefits or services meet all laws regarding confidentiality and a patient's right to their medical information
- Benefits or services may be delivered via synchronous video, synchronous audio-only, or asynchronous store and forward, so long as those services meet the standard of care and billing code requirements that apply to in-person service. Include the following modifiers when billing for services delivered via telehealth:
  - Synchronous video: 95
  - Synchronous audio-only: 93
  - Asynchronous store and forward: GQ
- Medi-Cal enrolled children or youth may request or decline delivery of services via telehealth modality



Required Services to Support Access (1 of 2)

Necessary Transportation To and From Appointments

- Providers must offer and assist with arranging non-emergency medical transportation (NEMT) and non-medical transportation (NMT) so children/youth under age 21 can receive Medi-Cal for Kids & Teens services
  - **NEMT** is transportation by ambulance, wheelchair van, or litter van for children whose medical and physical condition does not allow them to travel by public or private transportation
    - Providers must submit a Physician Certification Statement (PCS) form to the managed care plan for NEMT prior authorization
  - **NMT** is private or public transportation; families or the child/youth will need to attest to their provider verbally or in writing that they have an unmet transportation need and all other currently available resources have been reasonably exhausted
    - Providers need to confirm with the managed care plan if prior authorizations are required for NMT services, as it is up to the managed care plan to determine
  - Families or the child/youth may request or refuse transportation assistance at any time

Related Travel Expenses

- California's managed care plans must cover related travel expenses for medically necessary services at the child/youth's request, including the cost of meals and lodging for a child and parent, caretaker, relative, friend, or attendant for the purpose of obtaining needed medical care

Providers can direct families to the **Medi-Cal Member Help Line at 1-800-541-5555 or their Medi-Cal Managed Care Plan** for help accessing transportation and travel supports

Required Services to Support Access (2 of 2)

Language Assistance

- Managed care plans must provide **oral interpretation** for any non-English speaking family or child/youth, free of charge, at all medical encounters (such as an outpatient visit) and certain non-medical encounters (such as scheduling appointments)
- **Sign language interpreter services** must also be provided during all medical and certain non-medical encounters
- Managed care plans must **translate the member handbook and provider directory** into prevalent non-English languages when at least 3,000 or 5% of the managed care plan's members speak a non-English language, whichever is lower
  - The provider directory must include **cultural and linguistic capabilities of each provider**, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, or access to language line interpreters
  - Families, children and youth, and providers can call the **Office of Civil Rights at (916)-440-7370, 711 (California State Relay) or the Medi-Cal Member Help Line at 1-800-541-5555** for assistance accessing language services
- Managed care plans must provide **alternative formats of the member handbook; provider directory; and dental, termination, and appeal notices** such as braille, audio format, large print (no less than 20-point Arial font), and accessible electronic format (e.g., data CD)

Appointment Scheduling Assistance

- Providers must offer and provide, as requested, assistance with scheduling appointments for Medi-Cal for Kids & Teens services

Informing Families of Medi-Cal for Kids & Teens Services

Providers play an important role in communicating about Medi-Cal for Kids & Teens to children and families. A combination of face-to-face, oral, and written communication is recommended. Providers must inform all Medi-Cal eligible families of the services available to them under Medi-Cal for Kids & Teens, including:

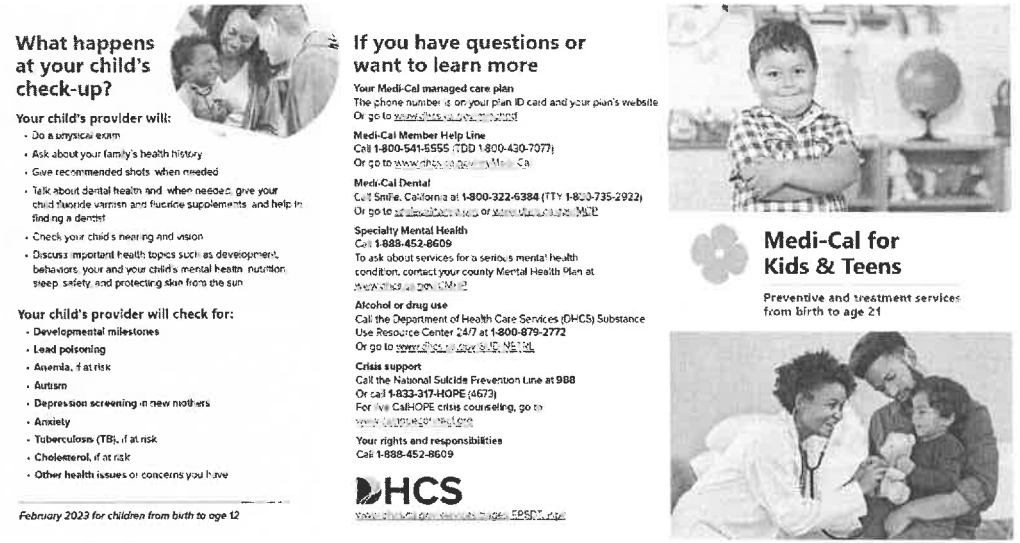
Benefits of preventive health and dental care	Tips and information for choosing a health or dental care provider	Nature and scope of Medi-Cal for Kids & Teens medical and dental services	Appointment scheduling and transportation assistance availability
Need for prompt diagnosis of suspected defects, illnesses, diseases or other conditions	Availability of treatment for problems diagnose during screening	Referrals to other providers for additional services not offered	Ability to ask for and receive services, even if the services were initially denied

DHCS and its managed care plans must identify children that are underutilizing Medi-Cal for Kids & Teens screenings and preventive services and ensure outreach to these children

Medi-Cal for Kids & Teens Enrollee Brochures

DHCS has developed brochures for children and families enrolled in Medi-Cal to increase knowledge and awareness of Medi-Cal for Kids & Teens. There are two brochures: (1) children ages 11 and under and (2) children and youth ages 12 through 20).

- Brochures are available in multiple languages here for providers to print and share in offices
- Providers are encouraged to print and share brochures broadly with families enrolled in Medi-Cal
- Managed care plans will distribute these brochures to families with children on an annual basis



What happens at your child's check-up?

Your child's provider will:

- Do a physical exam
- Ask about your family's health history
- Give recommended shots when needed
- Talk about dental health and when needed, give your child fluoride varnish and fluoride supplements and help in finding a dentist
- Check your child's hearing and vision
- Discuss important health topics such as development, behaviors, your and your child's mental health, nutrition, sleep, safety, and protecting skin from the sun

Your child's provider will check for:

- Developmental milestones
- Lead poisoning
- Anemia, if at risk
- Autism
- Depression screening in new mothers
- Anxiety
- Tuberculosis (TB), if at risk
- Cholesterol, if at risk
- Other health issues or concerns you have

February 2023 for children from birth to age 12

If you have questions or want to learn more

Your Medi-Cal managed care plan
The phone number is on your plan ID card and your plan's website
Or go to www.dhcs.ca.gov/mmcd

Medi-Cal Member Help Line
Call 1-800-541-5555 (TDD 1-800-430-7077)
Or go to www.dhcs.ca.gov/MyMediCal

Medi-Cal Dental
Call Smile, California at 1-800-322-6384 (TTY 1-800-735-2922)
Or go to smilecalifornia.org or www.dhcs.ca.gov/MCP

Specialty Mental Health
Call 1-888-452-8609
To ask about services for a serious mental health condition, contact your county Mental Health Plan at www.dhcs.ca.gov/CMHP

Alcohol or drug use
Call the Department of Health Care Services (DHCS) Substance Use Resource Center 24/7 at 1-800-879-2772
Or go to www.dhcs.ca.gov/SUD_NETWK

Crisis support
Call the National Suicide Prevention Line at 988
Or call 1-833-317-HOPE (4673)
For live CalHOPE crisis counseling, go to www.calhope.org

Your rights and responsibilities
Call 1-888-452-8609

DHCS

www.dhcs.ca.gov/services/Pages/EPSDT.aspx

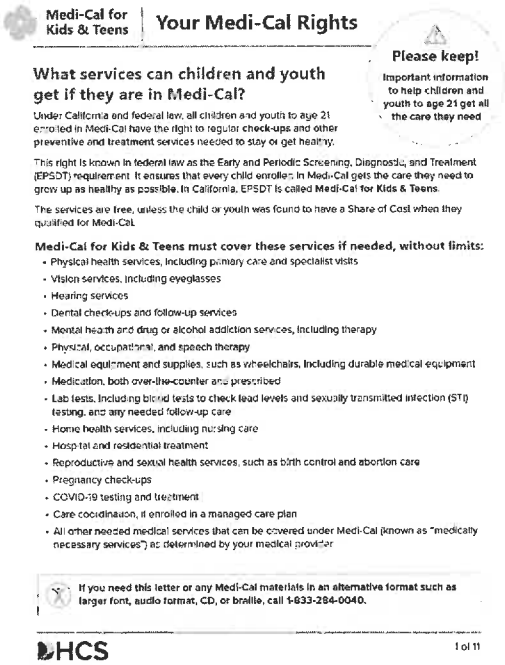
Medi-Cal for Kids & Teens

Preventive and treatment services from birth to age 21

Medi-Cal for Kids & Teens
Your Medi-Cal Rights Letter

DHCS has developed a letter for children and families enrolled in Medi-Cal outlining their rights in accessing Medi-Cal for Kids & Teens, as well as what to do when care is denied, delayed, reduced, or stopped.

- The letter is available in multiple languages here for providers to print and share in offices
- Providers are encouraged to print and share the letter broadly with families enrolled in Medi-Cal
- Managed care plans will distribute the letter to families with children on an annual basis



Medi-Cal for Kids & Teens | Your Medi-Cal Rights

Please keep!
Important information to help children and youth to age 21 get all the care they need

What services can children and youth get if they are in Medi-Cal?

Under California and federal law, all children and youth to age 21 enrolled in Medi-Cal have the right to regular check-ups and other preventive and treatment services needed to stay or get healthy.

This right is known in federal law as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement. It ensures that every child enrolled in Medi-Cal gets the care they need to grow up as healthy as possible. In California, EPSDT is called Medi-Cal for Kids & Teens.

The services are free, unless the child or youth was found to have a Share of Cost when they qualified for Medi-Cal.

Medi-Cal for Kids & Teens must cover these services if needed, without limits:

- Physical health services, including primary care and specialist visits
- Vision services, including eyeglasses
- Hearing services
- Dental check-ups and follow-up services
- Mental health and drug or alcohol addiction services, including therapy
- Physical, occupational, and speech therapy
- Medical equipment and supplies, such as wheelchairs, including durable medical equipment
- Medication, both over-the-counter and prescribed
- Lab tests, including blood tests to check lead levels and sexually transmitted infection (STI) testing, and any needed follow-up care
- Home health services, including nursing care
- Hospital and residential treatment
- Reproductive and sexual health services, such as birth control and abortion care
- Pregnancy check-ups
- COVID-19 testing and treatment
- Care coordination, if enrolled in a managed care plan
- All other needed medical services that can be covered under Medi-Cal (known as "medically necessary services") as determined by your medical provider

If you need this letter or any Medi-Cal materials in an alternative format such as larger font, audio format, CD, or braille, call 1-833-284-0040.

DHCS 1 of 11

Test Your Learning

- Can maternal depression screenings be provided during an infant's well-child visit?
- Can providers support children and families in obtaining transportation to a medical appointment?
- A child with a developmental disability needs additional screenings outside of the Medi-Cal for Kids & Teens Periodicity Schedule. Are these additional screenings covered by Medi-Cal?
- If a child breaks their glasses, can they get a new pair?
- If a child needs 10 hours of home health services but their Medi-Cal managed care plan only approved 8 hours, how can the provider get the decision reviewed?
- What age does Medi-Cal for Kids & Teens apply to – up to age 18 or 21?

Medi-Cal for Kids & Teens Training Modules



Module 1: What is Medi-Cal for Kids & Teens and How Does it Work?



Module 2: Deep Dive into Behavioral Health Services, California Children's Services Program, and Skilled Nursing Services

In This Module You Will Learn...



- What are Medi-Cal for Kids & Teens covered mental health services and SUD services
- How non-specialty mental health and specialty mental health differ from each other in Medi-Cal
- Which children are eligible for California Children's Services (CCS) or CCS Whole Child Model (WCM) and why
- How children can qualify for Medi-Cal for Kids & Teens covered skilled nursing services

Mental Health Services

Medi-Cal for Kids & Teens covers all medically necessary mental health services for children and youth under age 21 enrolled in Medi-Cal. There are two different systems that the State leverages to deliver mental health services depending on the child and youth's level of need, including:

Non-Specialty Mental Health Services (NSMHS)

» **Managed care plans** are responsible for providing medically necessary NSMHS for children and youth under the age of 21

» NSMHS are **"carved in"** to Medi-Cal Managed Care

Specialty Mental Health Service (SMHS)

» **County mental health plans** are responsible for providing medically necessary SMHS for children and youth under the age of 21

- If a child/youth meets the criteria for SMHS, then they should be receiving any SMHS from the mental health plan, except in cases where the No Wrong Door policy applies (see slide 45))

» SMHS are **"carved out"** of Medi-Cal Managed Care

Children and youth under age 21 do **not** require a diagnosis in order to receive mental health services.

Mental Health Services Screening and Transition Tools

- Providers are NOT required to use the **Youth Screening Tool for Medi-Cal Mental Health Services** for children and youth under age 21 who are not currently receiving mental health services and who contact the Medi-Cal managed care plan or county mental health plan directly seeking mental health services

- Providers are required to use the **Transition of Care Tool for Medi-Cal Mental Health Services** to ensure enrollees who are receiving mental health services from one delivery system receive timely transition of care referrals or services referrals to their managed care plan or county mental health plan

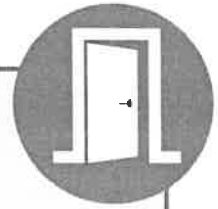


- Both county mental health plan and managed care plan providers will leverage this tool statewide to better identify appropriate behavioral health delivery systems and services that are child and family-centered

No Wrong Door Policy

DHCS implemented a "No Wrong Door" policy in July 2022 to ensure enrollees receive mental health services without delay regardless of where they initially seek care.

Clinically appropriate NSMHS and SMHS are covered and reimbursable even when:



- Services are provided **prior to determination of a diagnosis**, during the assessment period, or **prior to determination of whether NSMHS or SMHS access criteria are met**;
- Services are not included in an **individual treatment plan**; *(currently only applies to NSMHS; guidance forthcoming for SMHS)*
- The child has a **co-occurring mental health condition and SUD**; or
- NSMHS and SMHS services can be **provided concurrently**, if the mental health plan and managed care plan coordinate to provide the services and ensure they are not duplicated (each plan would only be responsible for the services they are providing). See the No Wrong Door for Mental Health Services Webinar (slide 17) for more information regarding providing concurrent services.

Non-Specialty Mental Health Services (NSMHS)

NSMHS (formerly known as Mild to Moderate services) include a variety of behavioral interventions that promote the functioning of children and youth and prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. Managed care plans must provide or arrange all medically necessary NSMHS for children and youth under age 21 regardless of their level of distress or impairment, or the presence of a diagnosis.

» **NSMHS include:**

- Mental health evaluation and treatment, including individual, group and family psychotherapy
- Dyadic services for children and their caregiver(s)
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition
- Outpatient services for purposes of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs (not including outpatient pharmacy benefits covered under Medi-Cal Rx), supplies, and dietary supplements (e.g., folic acid, vitamin D, vitamin B12)

» **Provider types include:**

- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Licensed Marriage and Family Therapist
- Licensed Psychologist
- Associate provider types may render services under a supervising clinician
- Psychiatric Physician Assistant
- Psychiatric Nurse Practitioner
- Psychiatrist (as consistent with the practitioner's training and licensing requirements)

For more information, please review the Non-Specialty Mental Health Services: Psychiatric and Psychological Services Provider Manual

County Specialty Mental Health Services

Each county mental health plan must provide or arrange all medically necessary SMHS for children and youth under age 21 enrolled in Medi-Cal who require more intensive mental health services.

County mental health plans must make individualized determinations of each child's need for SMHS. Examples include, but are not limited to:

- Intensive Care Coordination (ICC) (e.g., targeted case management for children in SMHS)
- Intensive Home-Based Services (IHBS) (e.g., interventions designed to correct or ameliorate conditions that interfere with functioning, and improve the family's ability to help the child successfully function at home/school/community)
- Therapeutic Foster Care (TFC) (e.g., short-term, trauma-informed, intensive SMHS for children with complex emotional and behavioral needs; in TFC, children are placed with trained and intensely supervised TFC parents)
- Therapeutic Behavioral Services (TBS) (e.g., short-term, intensive services for children with a SED)
- Psychiatric Health Facility Services and/or Inpatient Hospital Services (e.g., 24-hour inpatient care)
- Crisis Intervention, Stabilization, and/or Residential Services (e.g., community-based crisis intervention, short-term)
- Day Treatment Intensive and/or Rehabilitation Services (e.g., group therapy, skill building groups, short-term)
- Peer Support Services (optional)
- NSMHS- if a child meets the criteria for SMHS, then they may be receiving NSMHS from the Managed Care Plan, where the No Wrong Door policy applies (see slide 45)



SMHS may be provided during an assessment period for the child prior to the determination of a diagnosis or whether SMHS access criteria are met (see next slide for access criteria).

SMHS Access Criteria

For more information, please review BHIN 21-073

Covered SMHS shall be provided to children and youth who **meet either of the following criteria, (1) or (2) below:**

1. The child is at high risk for a mental health disorder due to experience of trauma (i.e., scores in the high-risk range under a trauma screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness)

OR

2. The child meets both requirements in a) and b), below:
   a) The child has at least **one** of the following:
      i. A significant impairment
      ii. A reasonable probability of significant deterioration in an important area of life functioning
      iii. A reasonable probability of not progressing developmentally as appropriate
      iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

   AND

   b) The child's condition as described in (2) above is due to one of the following:
      i. A diagnosed mental health disorder
      ii. A suspected mental health disorder that has not yet been diagnosed
      iii. Significant trauma placing the child at risk of a future mental health condition, based on the assessment of a licensed mental health professional

Substance Use Disorder Services (1 of 2)

Medi-Cal for Kids & Teens covers all medically necessary substance use disorder (SUD) treatment, such as outpatient care, residential treatment services, and withdrawal management. SUD services are primarily provided through DMC or DMC-ODS programs, depending on the county, and some SUD services are provided by managed care plans.



SUD treatment services are provided to eligible Medi-Cal enrollees, including children and youth under age 21, via county-run **Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS)** programs:

- Counties have the option to participate in the DMC-ODS program and provide an expanded array of SUD treatment services to Medi-Cal enrollees
- All counties, regardless of their participation in DMC-ODS, are required to provide all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Medi-Cal for Kids & Teens

Substance Use Disorder Services (2 of 2)

Though most SUD services are provided via DMC or DMC-ODS for children and youth, managed care plan providers must provide:

- SABIRT screening (see slide 22) to children starting at age 11 who are at risk of developing a SUD
- Early intervention SUD services for children and youth determined to be at risk of SUD (e.g., any service component covered under the outpatient level of care)
- Medications for Addiction Treatment (MAT) available in primary care, inpatient hospital, and emergency departments
- Emergency services to stabilize the child (including voluntary inpatient detoxification)



Some children may qualify for both SMHS and SUD services if they have a co-occurring SUD and mental health condition. **Providers are required to coordinate and collaborate across delivery systems** to ensure clinical integration between county mental health plans, DMC or DMC-ODS counties, and managed care plans, and to ensure non-duplicative services

Mobile Crisis Services

Medi-Cal for Kids & Teens covers qualifying mobile crisis services, including an initial face-to-face crisis assessment, crisis response and stabilization, crisis planning, referrals to ongoing services and supports, and follow-up. Mobile crisis services offer community-based interventions to individuals experiencing a mental health or substance use crisis and are available to Medi-Cal enrollees 24 hours a day, 365 days a year.

- Crisis intervention and habilitation services, including when delivered in a mobile modality, are always covered for children and youth under age 21
- Mobile crisis services can provide relief to youth experiencing a behavioral health crisis; reduce the risk or danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement
- In January 2023, counties began implementing the qualifying mobile crisis services benefit in the SMHS and DMC or DMC-ODS delivery systems
  - Counties will develop a standardized screening tool to determine when mobile crisis teams should be dispatched and other policies and procedures to ensure mobile crisis services are delivered effectively to children and youth
  - The qualifying mobile crisis services benefit will be available statewide in SMHS and DMC or DMC-ODS delivery systems by December 31, 2023



Psychiatric Collaborative Care Management Services

- **Overview.** Providers can bill for **psychiatric collaborative care management services** when they reach out to a psychiatric or addiction medicine consultant to help treat a child's mental health and/or SUD
- **Consent.** The child and their parent or caregiver must give permission to consult with relevant specialist; consent can be verbal and must be documented in medical record
  - Starting at age 12 and older, a child may, without parental consent, receive services related to drug and alcohol abuse treatment/counseling and mental health outpatient care
- **Billing Codes & Services.** Reimbursable CPT codes include 99492 (70 minutes in first month), 99493 (60 minutes in subsequent month), and 99494 (additional 30 minutes) for the following services in collaboration with a consulting provider:
  - Outreach and engagement in treatment with another qualified health care professional
  - Initial assessment of the child with a validated rating scale and development of a treatment plan
  - Review and modifications of the plan with the consulting provider
  - Tracking patient follow-up and entering info in a registry
  - Participating in weekly caseload consultation with consulting provider
  - Providing brief interventions

99492 and 99493 can be billed once per month, but not in the same month. 99494 can be billed twice per month

For additional information, see the Evaluation & Management Provider Manual re: Psychiatric Collaborative Care Management Services

County SMHS: Intensive Home-Based Services (IHBS) Example



- A ten-year-old child enrolled in Medi-Cal managed care has been experiencing issues with self-regulation and behavioral outbursts in school
- The child's pediatrician screens the child using the standardized screening tool and determines the child would benefit from SMHS
- The child's pediatrician refers the child to the county mental health plan
- A pediatric psychologist paneled at the county mental health plan conducts an additional assessment and determines that IHBS supports (e.g., interventions designed to correct or ameliorate conditions that interfere with functioning, and improve the family's ability to help the child successfully function at home/school/community) would be appropriate to effectively serve the child's intensive behavioral needs and engage the child's caregivers to support building functional skills
- The psychologist submits the IHBS mental health documentation requirements prescribed by the county mental health plan, consistent with the mental health plan's process for authorizing IHBS
- The county mental health plan agrees with the psychologist in determining that the IHBS services are medically necessary based on the child's strengths and needs
- The county mental health plan delivers IHBS to the child in their home and community setting

California Children's Services (CCS) Requirements for Primary Care Providers (1 of 2)

CCS is an important component of the Medi-Cal system of care available to qualifying children and youth under age 21 with certain diseases or health problems.

- The CCS Program, which is administered as a partnership between county health departments and DHCS, provides diagnostic and treatment services, medical case management, and physical and occupational therapy services
- Care for children enrolled in CCS is provided by CCS-paneled providers, CCS-approved special care centers (SCCs), and approved pediatric acute care hospitals
- The CCS Medical Therapy Program (MTP) provides direct physical and occupational therapy services for a subset of CCS-eligible children with physical disabilities
- Note: A child can be eligible for CCS services regardless of whether they are eligible for Medi-Cal or enrolled in a Medi-Cal managed care plan



Examples of CCS-eligible conditions include, but are not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, lead poisoning, and traumatic injuries.

California Children's Services (CCS) Requirements for Primary Care Providers (2 of 2)

Anyone can make a referral to the CCS Program, if they suspect that a child is eligible for CCS. Primary care providers or specialists must provide a baseline health assessment and diagnostic evaluation with sufficient clinical to establish – or raise a reasonable suspicion – that a child has a CCS-eligible medical condition.

- Children with CCS-eligible conditions must be referred to the local CCS Program on the same day after the condition is identified
- Referrals can be made via phone, secure email, mail, or fax, and include supporting medical documentation sufficient to allow for a medical eligibility determination
- Access here for the list of phone and fax numbers for each local CCS Program

Providers must continue to provide all covered services until the CCS Program eligibility is determined, and the managed care plan must reimburse the provider for those services.

Classic CCS Counties & CCS WCM Counties



Counties in **pink** are **CCS WCM counties** and counties in **blue** are **CCS counties** (see Appendix 2 for a full county list)

- California's 58 counties provide CCS through two different models:
  - In Classic CSS counties, the treatment for the CCS qualifying condition, including medical case management, is provided directly through the CCS county office
  - In CCS Whole Child Model (WCM) counties, the treatment for the CCS qualifying condition, including medical case management, is "carved in" to the managed care plan's responsibility
- The eligibility criteria for CCS are the same in both Classic CCS and CCS WCM counties
- If the local CCS Program or DHCS finds that the child's condition is not medically eligible, then the managed care plan in both Classic CCS and CCS WCM counties remains responsible for providing and reimbursing for the cost of services if determined to be medically necessary
- Local CCS county offices or DHCS determine if a child is eligible for CCS in both Classic CCS and CCS WCM counties
  - Counties with populations greater than 200,000 – known as **independent counties** – have county staff perform medical eligibility determinations
  - Counties with populations less than 200,00 may choose to be independent counties or **dependent counties;** DHCS is responsible for determining medical eligibility for dependent counties

Medi-Cal for Kids & Teens Skilled Nursing Services (1 of 2)

Skilled nursing services are critical for children and youth with serious physical health conditions, many of whom often qualify for CCS.

- Children and youth under age 21 may be eligible for Medi-Cal for Kids & Teens Skilled Nursing Services, including:
  - **Private Duty Nursing (PDN)** is skilled nursing services provided by a licensed nurse (RN or LVN) on a shift basis at a child's home for children who require more individualized and continuous care than what would be provided by a visiting nurse; otherwise known as 'shift' nursing
  - **Pediatric Day Health Care (PDHC)** is skilled nursing services provided as day programs at PDHC facilities of less than 24 hours, including (but not limited to) comprehensive case management; nutrition and nursing services; developmental and educational services; and physical, occupational, speech therapy



*Limits based on a monetary cap or budgetary constraint may **not** be imposed; for example, if a provider determines it is medically necessary for a child to have 20 hours per week of private duty nursing, then the managed care plan cannot limit the service to 10 hours per week*

Medi-Cal for Kids & Teens
Skilled Nursing Services (2 of 2)

Providers must refer a child for skilled nursing services if they determine the services are medically necessary for the child. Service authorization for PDN and PDHC include:

CCS–Eligible Members	CCS WCM–Eligible Members	Non-CCS-Eligible Members
» Providers must fax or secure email a service authorization request (SAR) to the child's local CCS County office or upload the SAR into the Provider Electronic Data Interchange (PEDI) for the local CCS county office or DHCS to adjudicate the PDN or PDHC service request » Providers must submit with the SAR a Plan of Treatment (POT) signed by a CCS paneled physician and supporting clinical documentation such as medical records and discharge summary notes	» Providers must submit a prior authorization request to the managed care plan to approve or deny the PDN or PDHC service request » Providers must submit with the prior authorization request a POT, supporting clinical documentation, and other information, as specified by the managed care plan for review and authorization	» Providers must submit prior authorization requests to the managed care plan to approve or deny the PDN or PDHC service request » Providers must submit with the prior authorization request a POT, supporting clinical documentation, and other information, as specified by the managed care plan for review and authorization

Medical Necessity Review Criteria: Private Duty Nursing Example



» An infant with chronic lung disease has a tracheostomy and ventilator and requires PDN services » The infant is enrolled in the CCS Program and enrolled in a managed care plan in a Classic CCS County
» The CCS-paneled provider submits a SAR requesting RN-level PDN services to be performed in the child's home; attachments include the POT signed by the CCS paneled physician and supporting clinical documentation
» The CCS Program adjudicator determines that the services requested relate to the CCS-eligible condition and they conduct a medical-necessity review and determine that the services are within the scope of an LVN
» The CCS Program adjudicator modifies the SAR to reflect the appropriate provider type to render the PDN services and approves the PDN services and units

Test Your Learning

- Do children without diagnosed mental health conditions qualify for mental health services provided by managed care plans and/or mental health plans?

- Can a child receive services from a managed care plan, county mental health plan, and Drug Medi-Cal (DMC)/Drug-Medical Organized Delivery System (DMC-ODS) county at the same time?

- If you believe a child would benefit from family therapy or other supports, are those services available under Medi-Cal for Kids & Teens?

- How does a child enrolled in Medi-Cal managed care and *not* eligible for CCS receive skilled nursing services?

Appendix

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Billing Codes

Service Category	Billing Codes
Blood lead screening	CPT 36415, 36416, 83655, 99401, 99402, 99403, 99404
Developmental screening	CPT 96110
ASD screening	CPT 96110 and modifier KX
Depression screening	HCPCS G8431 and G8510
Postpartum depression screening	HCPCS G8431 and G8510
Vision screening	CPT 99173*, 99381-99385 and 99391-99395 **For school-based enrolled Medi-Cal providers only*
Hearing screening	CPT 92551 and 92552; ICD-10-CM diagnosis codes Z00.121, Z00.129, Z01.10, or Z01.11
Oral health screening	CPT 99188, 99381 – 99383, 99391 – 99393; HCPCS D1206
ACEs/trauma screening	HCPCS G9919, G9920
Dyadic services	HCPCS H1011, H2015, H2027, T1027
As needed screenings	As needed screenings should be billed using the appropriate preventive medicine CPT code and ICD-10 CM diagnosis code Z00.8 (encounter for other general examination)

Classic CCS Counties & CCS WCM Counties (2 of 2)



KEY

- ☐ CCS WCM counties
- ☐ CCS counties

Sources

For the list of sources related to this training, please refer to the "MCKT Provider Training Sources" located on the MCKT Website, Provider Information page.

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

CalOptima Health

Provider Manual



TABLE OF CONTENTS

SECTION A: INTRODUCTION

Welcome to CalOptima Health A1
Intent of the Provider Manual A1
How to Use the Manual A1
Overview of CalOptima Health Programs A1
Who is Covered with CalOptima Health Programs A1
Delivery System Structure for CalOptima Health Programs A1

SECTION B: PROVIDER RESOURCES

CalOptima Health Department and Program Contact Information B1
Provider Resources on CalOptima Health's Website B2
CalOptima Health Liaison Roles and Responsibilities B3

SECTION C: COVERED SERVICES

Covered Services C1
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Referrals C2
Hospice Service Referrals C3
Long-Term Care (LTC) Service Referrals C4
Multipurpose Senior Services Program (MSSP) C5
Long-Term Services and Supports (LTSS) C6
Pediatric Preventive Services (PPS) C7
Perinatal Support Services (PSS) C8
Vision Services C9
Mental Health Services C10
Drug and Alcohol Abuse Services C11
Telehealth Services C12
Doula Services C13
Community Health Worker Services C14
Responsibilities for Indian Health Care Providers (IHCP) and American Indian Members C15

County Child Welfare Liaison C16
Enhanced Care Management C17
Community Supports C18
Transplants C19

SECTION D: SERVICES COVERED BY OTHER AGENCIES

AIDS Waiver Services Referrals D1
Drug and Alcohol Abuse Services D2
Whole Child Model and California Children's Services D3
Dental Services for Medi-Cal Members D4
Home and Community-Based Services Referrals D5
Regional Center of Orange County (RCOC) Services D6

SECTION E: ELIGIBILITY VERIFICATION AND ENROLLMENT

Verifying Member Eligibility E1
Medi-Cal Recipients Not Enrolled in CalOptima Health E2
CalOptima Health's Medi-Cal, OneCare (HMO D-SNP) Member ID Card E3
Medi-Cal Share of Cost Members E4
Share of Cost for Long-Term Care Services E5

SECTION F: AUTHORIZATION AND REFERRAL GUIDELINES

Authorization for Medical Services* F1
Services Not Requiring Authorization F2
Self-Referrals and Direct Referrals* F3
Second Opinions* F4
Tips to Expedite CalOptima Health Direct Authorization Requests F5
CalOptima Health Direct Services Requiring Authorization F6
CalOptima Health Direct Retroactive Authorization Request F7
Wheelchair Authorization and Repair Requests F8
Non-Emergency Medical Transportation (NEMT) Requests F9
Incontinence Supply Information F10

SECTION G: AUTHORIZATION PROCESS FOR LONG-TERM CARE

Introduction G1
Long-Term Care (LTC) Department Contacts G1
Quick Reference for the LTC Authorization Process G1
Initial Authorization: SNF, ICF G2
Reauthorization: Regular-SNF, ICF G3
Initial Authorization: ICF/DD, ICF/DD-H, ICF/DD-N G4
Reauthorization-Regular: ICF/DD, ICF/DD-H, ICF/DD-N G5
Initial Authorization: Subacute-Adult and Pediatric G6
Reauthorization: Subacute-Adult and Pediatric G7
Retroactive Eligibility: Authorization and Process Guidelines G8
Bed Hold and Leave of Absence: Authorization Requests G9
Deferred Long-Term Care (LTC) Authorization Request Forms (ARF) G10
Discharge Notification G11
Nursing Facility NF-A Level of Care Criteria G12
Criteria for Admission and Continued Stay-SNF G13
LTC ARF Process and Criteria: Nursing Facility Level A (NF-A) and Level B (NF-B) G14

SECTION H: CLAIMS AND BILLING GUIDELINES

Claims Submission H1
Claims Processing Overview: COHD, Shared Risk, OneCare (HMO D-SNP) Claims H2
Electronic Claims Submission: COHD, Shared Risk, OneCare (HMO D-SNP) Claims H3
Hard Copy Claims Submission: COHD, Shared Risk, OneCare (HMO D-SNP) Claims H4
Submitting Crossover Claims H5
Claims Rejection Notice H6
Other Health Coverage H7
Common Claims Denials and Rejects: COHD, Shared Risk and OneCare (HMO D-SNP) H8
Reconciling CalOptima Health Direct and OneCare (HMO D-SNP) Payments H9
National Drug COHD Billing Guidelines for CalOptima Health Direct H10
PDR Process: COHD, Shared-Risk and OneCare (HMO D-SNP) Claims H11
Member Billing Restrictions H12
Sterilization Consent H13

SECTION I: PHARMACY AND PRESCRIBER INFORMATION

Formulary Information I1
Physician Administered Drugs Prior Authorization Request List I2
Pharmacy Prior Authorization I3
Medication Therapy Management Program I4
Pharmacy Network I5

SECTION J: CASE MANAGEMENT

Complex Case Management J1
Case Management for Children with Special Health Care Needs J2
End-Stage Renal Disease (ESRD) Case Management J3
Hemophilia Case Management J4
Referring Members for Case Management J5
Model of Care J6
Continuity of Care J7

SECTION K: COMMUNITY RESOURCES, SOCIAL AND SUPPORTIVE SERVICES

Child Protective Services K1
Local Education Agency Services K2
Tuberculosis Directly Observed Therapy Services K3
Women, Infants, and Children (WIC) Services K4
Coordination with Community Resources and Social Services K5

SECTION L: CONTRACTING AND PROVIDER REGISTRATION

Contracting with CalOptima Health* L1
Provider and Practitioner Registration L2

SECTION M: QUALITY MANAGEMENT

Credentialing and Recredentialing M1
Facility Site Review, Medical Records Review and Physical Accessibility Review M2
Initial Health Appointment (IHA) M3
Clinical Practice Guidelines M4
HEDIS Measures and Reporting M5
Access Standards* M6
Reporting Potential Quality of Care Issues M7

SECTION N: CUSTOMER SERVICE

Assistance from CalOptima Health's Customer Service Department* N1
Member Liaison Program for Seniors and Persons with Disabilities (SPD) N2
Health Network and Primary Care Provider (PCP) Selection* N3
Member Rights and Responsibilities* N4
New Member Materials* N5
Obtaining Assistance with Cultural and Linguistic Services N6
Accessing Interpreter Services N7
Tips for Documenting Interpreter Services N8
Tips for Working with Interpreters N9
Tips for Working with Limited English Proficient (LEP) Members N10
Cultural Competency Training N11

SECTION O: HEALTH EDUCATION

Health and Wellness Services O1
Basic Population Health Management O2

SECTION P: COMPLIANCE

Fraud, Waste or Abuse Investigating and Reporting P1
About HIPAA Privacy P2

SECTION Q: PROVIDER RESPONSIBILITIES

Role of Primary Care Provider (PCP)* Q1

Member Medical Record..... Q2

SECTION R: PROVIDER COMPLAINT PROCESS

Provider Complaint Process..... R1

Time Limits for Filing* R2

Required Documentation for Complaints R3

Addresses for Filing Provider Complaints R4

Time Frame for Resolution of Complaints: Non-Contracted Providers R5

Filing on Behalf of a Member..... R6

State Fair Hearing Rights R7

Legal Claims and Judicial Review R8

SECTION S: PACE

Introduction S1

Participant Rights and Responsibilities S2

Participant Grievance Process.....S3

Participant Appeal Process S4

Provider Rights and Responsibilities S5

Quality Management and Credentialing.....S6

Claim Submission and Process S7

Utilization Management and Authorization for Services S8

Sensitive and Confidential Services S9

Additional Resources and Information S10

**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. Any reference to OneCare (HMO D-SNP) applies to all OneCare Plans.*

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 (CHCN).

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 – AHNAltaMed 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

Health Network*	CalOptima Health Program	Delegated Responsibilities
AMVI/Prospect Medical Group	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.
CalOptima Health Community Network (CHCN)	Medi-Cal, OneCare, CalOptima Health Direct	Professional, facility and ancillary services
CHOC Health Alliance	Medi-Cal	Professional, facility and ancillary services
Family Choice Health Services Family Choice 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.
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
Providence	Medi-Cal	Professional services and ancillary services are the responsibility of the Shared-Risk Group. Facility services and some ancillary services are the responsibility of CalOptima Health.
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) 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 Health Services – AHN (HMO) Medi-Cal	1401 N. Montebello Blvd. Montebello, CA 90640	General: 855-848-5252 Claims: 855-848-5252 Authorizations: 855-848-5252 Medi-Cal Website: www.altamedhn.com TTY Line: 1-800-735-2922

Health Networks	Addresses	Phone Numbers and Website Addresses
AltaMed Health Services (SRG) OneCare	1401 N. Montebello Blvd. Montebello, CA 90640	General: 855-848-5252 Claims: 855-848-5252 Authorizations: 855-848-5252 Website: https://www.altamed.org/ TTY Line: 1-800-735-2922
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: www.amvimedicalgroup.com
CHOC Health Alliance (PHC) Medi-Cal	1120 W. La Veta Ave. Suite 800 Orange, CA 92868	General: 800-424-2462 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 107 Westminster, CA 92863	General: 800-611-0111 (toll free) Authorizations: 800-611-0111 (toll free) Website: www.familychoice.com
HPN-Regal Medical Group (HMO) Medi-Cal, OneCare	8501 Fallbrook Avenue Suite #300 West Hills, CA 91304	General: 844-292-5173 24-Hour: 844-292-5173 (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	9 Technology Drive Irvine, CA 92618	General: 888-656-7523 (toll free) Claims: 888-767-2222 24-Hour: 888-656-7523 (toll free) Website: www.optum.com/california
Prospect Medical Group (HMO) Medi-Cal, OneCare	600 City Parkway West Suite 1000 Orange, CA 92868	General: 833-303-4551 24-Hour: 833-303-4551 Website: www.prospectmedical.com

Health Networks	Addresses	Phone Numbers and Website Addresses
Providence (SRG) Medi-Cal	15480 Laguna Canyon Rd. Irvine, CA 92617	General: 855-359-6323 Claims: 855-848-5252 Authorizations: 714-449-4923 Website: providence.org TTY Line: 711 Fax: 714-712-3393 (UM) 714-937-6142 (Claims) 714-937-7066 (Out of network inpatient authorizations) Out-of-network inpatient authorizations: 844-499-0066
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: https://www.unitedcaremedicalgrp.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

B3: CALOPTIMA HEALTH'S LIAISONS ROLES AND RESPONSIBILITIES

CalOptima Health is required to designate an individual or set of individuals to serve as the day-to-day liaisons for specific services and programs as set forth in the list below to ensure services are closely coordinated with members' other services and to ensure effective oversight and delivery of services. Liaisons are required to receive training on the full spectrum of rules and regulations pertaining to the service they are coordinating, including referral requirements and processes, care management, and authorization processes.

TRIBAL LIASION ROLES AND RESPONSIBILITIES

CalOptima Health is required to have an identified tribal liaison dedicated to working with each contracted and noncontracted Indian Health Care Provider (IHCP) in its service area. The tribal liaison is responsible for coordinating referrals and payment for services provided to American Indian members who are qualified to receive services from an IHCP. The role and responsibilities of the CalOptima Health tribal liaison include, but are not limited to:

- Providing information to IHCPs regarding enrollment and disenrollment of American Indian members
- Coordinating care with in- and out-of-network IHCPs for American Indian members
- Ensuring access to care with in- and out-of-network IHCPs for American Indian members
- Providing assistance to IHCPs and American Indian members with accessing appropriate transportation, given logistical and geographical barriers unique to tribal communities
- Providing case management for American Indian members that involves in- and out-of-network IHCPs
- Assisting IHCPs with provider relations services, claims and payment assistance and resolution, and member services
- Providing support in obtaining grievance, appeal and State Hearing services to IHCPs in cases that impact American Indian members
- Providing benefits and services navigation and coordination, such as those for child welfare, Community-Based Adult Services (CBAS), Enhanced Care Management (ECM), Community Supports, Behavioral Health, Health Education, Home- and Community-Based Services, California Children's Services (CCS), etc., for IHCPs in order to provide full-spectrum services to American Indian members
- Assisting internal liaisons in instances that involve IHCPs and/or American Indian members and the other liaison's respective services and program, in particular the county child welfare liaison given the observed disproportionate representation of American Indian youth in the child welfare system; as well as the liaisons for Long-Term Services and Supports (LTSS), transportation, CCS, Regional Center, dental, and In-Home Supports and Services (IHSS)
- Providing assistance to IHCPs regarding Medi-Cal program provider enrollment and contracting, credentialing and Facility Site Reviews
- Attesting to the completion of the Cultural Humility training from the California Governor's Office of the Tribal Advisor, the Overview of Trauma-Informed Care and Historical Trauma training from the Indian Health Service (IHS), and other relevant trainings as they are developed and noted by DHCS

Additionally, DHCS strongly encourages CalOptima Health tribal liaisons to commit to the following activities to enhance relationships between CalOptima Health, IHCPs and American Indian members:

- Providing assistance to CalOptima Health's Member Services department in situations involving American Indian members
- Representing CalOptima Health and providing assistance to subcontractors to address inquiries and/or instances involving American Indian members
- Participating in the CalOptima Health Community Advisory Committee and other CalOptima Health committees that potentially impact American Indian members
- Attending and participating in tribal consultations involving tribes within CalOptima Health's service area
- Attending and participating in DHCS' Tribal and Designees of Indian Health Programs Quarterly Meeting, and other relevant meetings
- Developing tribal-specific outreach and educational materials
- Hosting marketing events and developing marketing materials focused on tribal health, as permitted
- Collaborating with other MCP tribal liaisons to discuss best practices, lessons learned, and the sharing of information and resources
- Collaborating with local tribal communities on the development of regional and culturally appropriate trainings for staff
- Having knowledge and consideration of Indigenous Determinants of Health when determining quality metrics and data reporting

IHSS LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must designate a person to serve as the day-to-day IHSS liaison with the county IHSS agency. CalOptima Health, in collaboration with the county IHSS agency, must ensure the liaison is sufficiently trained on IHSS assessment and referral processes and providers, and how CalOptima Health and PCPs can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports. This includes training on IHSS referrals for members in inpatient and Skilled Nursing Facility (SNF) settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings. The IHSS liaison functions may be assigned to the LTSS liaison if they meet the training requirements and have the expertise to work with the county IHSS liaison. The role and responsibilities of the CalOptima Health IHSS liaison include, but are not limited to:

- Coordinating with the county IHSS agency to ensure members do not receive duplicative services through ECM, Community Supports and other services
- Tracking all members receiving IHSS and continuing to coordinate services with the county IHSS agency for members until IHSS notifies CalOptima Health that IHSS is no longer needed for the member
- Outreaching and coordinating with the county IHSS agency for any members identified by DHCS as receiving IHSS
- Identifying members receiving, referred to, or approved for IHSS and conducting a reassessment of members' risk tier
- Continue providing basic population health management and care coordination of all medically necessary services while members receive IHSS

LTSS LIASION ROLES AND RESPONSIBILITIES

The role and responsibilities of the CalOptima Health LTSS liaison include, but are not limited to:

- Beginning in calendar year 2026, CalOptima Health must hold an "office hours" webinar at least once per calendar quarter for all eligible providers furnishing Long-Term Care (LTC) services to present

updates related to policies and procedures pertaining to LTC services and answer frequently asked questions.
    - The webinar must allow providers to participate virtually via telephone and optionally via an online teleconference service.
    - The webinar must provide the capability and opportunity for providers to ask live questions.
    - The LTSS liaison must publish the date and time of the webinar and instructions to join and notify all applicable providers at least 30 days prior to the webinar.
- Receive training on the full spectrum of rules and regulations pertaining to Medi-Cal-covered LTC, including resident rights under state and federal law, payment and coverage policies, prompt claims payment requirements, provider dispute resolutions policies and procedures, and care management, care coordination and Transitional Care Services policies.
- Serve as a single point of contact for service providers in both a provider representative role and to support care transitions, as needed.
- LTSS liaisons must assist service providers in addressing claims and payment inquiries in a responsive manner and assist with care transitions among the LTSS provider community to best support a member's needs.
- Notify providers of any changes to the LTSS liaison as soon as reasonably practical, but no later than the date of change, and must notify DHCS within five days of the change.

TRANSPORTATION LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must have a direct line for providers and members to receive real-time assistance directly from CalOptima Health with unresolved transportation issues that can result in missed appointments. The liaison role may not be delegated to a transportation broker. CalOptima Health must have a process to triage urgent transportation calls when the member or provider communicates that they have attempted to work with the broker, but the issue remains unresolved and is time sensitive.

CCS LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must designate at least one individual to serve as the CCS liaison and serve as the primary point of contact responsible for the CCS members' care coordination. CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management, and authorization processes for CCS children.

COUNTY CHILD WELFARE LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must designate at least one individual to serve as the county child welfare liaison. Additional county child welfare liaisons must be designated as needed to ensure the needs of members involved with child welfare are met. The role and responsibilities of the county child welfare liaison include, but are not limited to:

- Having expertise in child welfare services and county behavioral health services
- Ensuring appropriate ECM staff, including the ECM lead care manager whenever possible, attend meetings of the child and family teams, in accordance with W&I section 16501(a)(4), and ensuring covered services are closely coordinated with other services, including social services and specialty mental health care services
- Acting as a resource to the ECM providers providing services to child welfare-involved children and youth
- Providing technical assistance to CalOptima Health and ECM provider staff as needed

- Serving as a point of escalation for care managers if they face operational obstacles when working with county and community partners
- Being sufficiently trained on county care coordination and assessment processes
- Coordinating with county child welfare liaisons for other Medi-Cal managed care plans to notify them when members cross county lines and/or change managed care plans
- Serving as a family advocate

DENTAL LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must have an identified liaison available to Medi-Cal dental providers to assist with referring members to other covered services. Other covered services include, but are not limited to, laboratory services, preadmission physical examinations required for admission to an outpatient surgical service center, or an inpatient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). The role and responsibilities of the dental liaison include, but are not limited to:

- Ensuring that dental screenings and oral health assessments are included for all members
- Ensuring that all members are given referrals to appropriate Medi-Cal dental providers
- Coordinating and providing medically necessary Federally Required Adult Dental Services (FRADS), fluoride varnish and dental services that may be performed by a medical professional
- For members less than 21 years of age, CalOptima Health must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the member's first tooth or at 12 months of age, whichever occurs first
- Ensuring the provision of medically necessary dental-related covered services that are not exclusively provided by dentists or dental anesthetists

CalOptima Health may require prior authorization for medically necessary covered services needed in support of dental procedures. If CalOptima Health requires prior authorization in support of dental procedures, CalOptima Health must develop and publish the policies and procedures for obtaining prior authorization for dental services to ensure that services are provided to the member in a timely manner. CalOptima Health must coordinate with DHCS Medi-Cal Dental Services Division in the development of its policies and procedures pertaining to prior authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

REGIONAL CENTER (RC) LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must designate its own liaison to coordinate with each RC operating within CalOptima Health's service area. The role and responsibilities of the RC liaison include, but are not limited to:

- Assisting members with developmental disabilities (DDs) in understanding and accessing services
- Acting as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10)
- Referring members with DDs to RCs for evaluation and access to nonmedical services provided by the RC, including, but not limited to, respite, out-of-home placement and supportive living
- Having a memorandum of understanding (MOU) in place as required in Exhibit A, Attachment III, Section 5.6 (MOUs with local government agencies, county programs and third parties) to coordinate services for the member with RC staff to ensure the nonduplication of services
- Creating the individual developmental services plan required for all members with DDs, which includes identification of the member's medical needs and the provision of medically necessary services such as medical care, Non-Specialty Mental Health Services (NSMHS) and Behavioral Health Treatment (BHT)

- Maintaining policies and procedures to identify and refer eligible members to the Home- and Community-Based Services (HBCS) program administered by the Department of Developmental Services (DDS)

For more information about the services and programs referenced in this Provider Manual, please see the following sections:

- Section C6: Long-Term Support Services (LTSS) (for LTSS and IHSS)
- Section C15: Responsibilities for Indian Health Care Providers (IHCP) and American Indian Members
- Section C16: County Child Welfare Liaison
- Section D3: California Children's Services
- Section D4: Dental Services for Medi-Cal Members
- Section D6: Regional Center of Orange County Services
- Section F9: Non-Emergency Medical Transportation Requests

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 covered 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:

- Acupuncture*
- Acute (short-term treatment) home health therapies and services
- Adult immunizations (shots)
- Allergy testing and injections
- Ambulance services for an emergency
- Anesthesiologist services
- Asthma prevention
- Audiology*
- Behavioral health treatment*
- Cardiac rehabilitation
- Chemotherapy and radiation therapy
- Chiropractic services*
- Cognitive health assessments
- Community health worker services
- Dental services — Limited (performed by medical professional/primary care provider [PCP] in a medical office)
- Dialysis/hemodialysis services
- Doula services
- Durable Medical Equipment (DME)*, including tracheostomy supplies
- Dyadic services
- Emergency care services
- Emergency room visits
- Enteral and parenteral nutrition*
- Family planning
- Family planning office visits and counseling (you can go to a non-participating provider)
- Habilitative services and devices*
- Health education programs
- Hearing aids
- Home health care*
- Hospice
- Hospice care*
- Hospital inpatient and outpatient services
- Immunizations
- Inpatient medical and surgical care*
- Lab and radiology*
- Lab tests and X-rays
- Long-term care and skilled nursing care services

- Long-term home health therapies and services*
- Major organ transplant*
- Maternity and newborn care
- Maternity care services
- Medical supplies
- Mental health and substance use disorder services
- Occupational therapy*
- Orthotics/prostheses*
- Ostomy and urological supplies
- Outpatient hospital services
- Outpatient mental health services
- Outpatient surgery*
- Palliative care*
- PCP visits
- Pediatric preventive services (Children's Presumptive Eligibility (CPE))
- Pediatric services
- Physical therapy*/occupational therapy
- Physician services
- Podiatry services*
- Prenatal care
- Prescription drugs
- Prosthetics and orthotics
- Pulmonary rehabilitation
- Rapid whole genome sequencing
- Rehabilitation services and devices*
- Skilled nursing services
- Specialist visits
- Speech therapy*
- Surgical services
- Telemedicine/telehealth
- Tracheostomy
- Transgender services*
- Transportation — Emergency
- Transportation — Non-emergency medical transportation (NEMT) services
- Urgent care
- Vision services*
- Women's health services

* *Require prior authorization*

Maternity and Newborn Care

CalOptima Health covers these maternity and newborn care services:

- Birthing center services
- Breast pumps and supplies
- Breastfeeding education and aids
- Care coordination
- Certified nurse midwife (CNM)
- Counseling
- Delivery and postpartum care

- Diagnosis of fetal genetic disorders and counseling
- Doula services
- Licensed midwife (LM)
- Maternal mental health services
- Newborn care
- Nutrition education
- Pregnancy-related health education
- Prenatal care
- Social and mental health assessments and referrals
- Vitamin and mineral supplements

MEDI-CAL-COVERED SERVICES NOT ADMINISTERED BY CALOPTIMA HEALTH

CalOptima Health does not administer certain Medi-Cal-covered services. The following identifies these services and where in the Provider Manual or online to learn more about how to refer for them:

- 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: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications

ONECARE SERVICES OVERVIEW

OneCare's covered benefits include services 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:

- Acupuncture and other alternative therapies
- Chiropractic services
- Diagnostic tests, X-rays, lab and radiology services
- DME
- Emergency services
- Health club membership/fitness classes
- Hearing services
- Home health care
- Hospice
- Inpatient hospital care
- Inpatient mental health services
- Medically necessary ambulance services
- NEMT
- Outpatient mental health services

- Outpatient rehabilitation services
- Outpatient substance abuse services
- Physician services
- Podiatry services
- Prescription drugs
- Prosthetic devices
- Skilled nursing facility
- Urgent care
- Vision services

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 provide a comprehensive array of preventive, diagnostic and treatment services for Medi-Cal-eligible individuals under the age of 21. EPSDT is designed to ensure this population receives early detection and care, so health problems are averted or diagnosed and treated as early as possible.

EPSDT services include medically necessary behavioral health treatment (BHT). 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
- Screening for mental health and substance use disorders
- BHT
- Chiropractic services
- Cochlear implants
- Case management services
- Hearing services, including hearing evaluation, treatment and hearing aid batteries
- In-home private duty nursing
- Medical nutrition services
- Occupational therapy, speech therapy and physical therapy
- Pediatric day health care

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. These requests will be approved when the medical necessity criteria have been met. Cases in which medical necessity criteria have not been met will be denied or modified, as appropriate, to meet the member's needs.

- 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 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. For example, 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 the home is an appropriate environment for providing the requested services.

HOW TO REFER A MEMBER FOR EPSDT

1. If a provider has a member who requires EPSDT services, except for BHT, the provider should complete an Authorization Request Form (ARF) and submit it to either CalOptima Health (if the member is in COD) 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 includes **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.

If a provider has a member who requires BHT, they should direct the member to call CalOptima Health Behavioral Health at **855-877-3885** (TTY **711**)**.** This line is available 24/7.

CalOptima Health Policies and Procedures:

GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) 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 community setting (home, assisted living, 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: Starting with the third benefit period, a hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of the member. Failure to have this face-to-face encounter will result in a failure by the hospice provider to certify the terminal diagnosis and meet eligibility requirements. The member would cease to be eligible for the benefit.

- Time frame of face-to-face encounters:
  - The encounter 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 CHCN, 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 they meet 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 CHCN) 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 CHCN** — If a member is in COD or CHCN, 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 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. Members will be referred to in-network hospice providers unless medically necessary services are not provided in-network.

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.
   - Hospice providers must notify CalOptima Health within five calendar days of initial certification and election of hospice care services.
   - Hospice providers must submit the following to CalOptima Health or the relevant health network for each benefit period (two initial 90-day periods and subsequent 60-day periods):
     - A DHCS Hospice Election Notice (NOE) that is properly completed and submitted within five calendar days of initial certification and election of hospice care services.
     - Hospice Certification of Terminal Illness.
     - Physician referral signed by the member's attending physician.
     - A written plan of care established by the attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care.
     - Licensing and Enrollment Proof (unless on file with CalOptima Health) – CDHP license, Medicare certification, NPI and Medi-Cal enrollment.
     - Face-to-Face Encounter Attestation

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

The Multipurpose Senior Services Program (MSSP) helps frail, elderly Medi-Cal members remain in their homes and avoid hospital or nursing home admissions. 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 age 60 or older
- Have a possible need for nursing home care
- Be enrolled in Medi-Cal with the right aid code

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 have a need for, as well as an ability and willingness to participate in, care management.

- "Need for care management" means the member requires assistance in accessing community services, maintaining or effectively using available services, or managing serious health conditions.
- "Ability/willingness to participate" means 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 their home environment.

CASE MANAGEMENT AND COORDINATION OF CARE

- CalOptima Health and its affiliated health networks will work with the MSSP provider to provide case management and coordination of care for 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 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 provider for eligibility determination.
- CalOptima Health and the MSSP provider will coordinate and work collaboratively on care coordination activities for the member.
- CalOptima Health will notify the MSSP provider within five business days of a member's disenrollment from CalOptima Health.
- MSSP providers will accept referrals from any sources, including a CalOptima Health case manager, health networks, members, a 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 CDA to host the MSSP site. MSSP is budgeted and reimbursed through a monthly reconciliation of CalOptima Health members 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, comorbidity, complexity of medical condition and functional status.
- CalOptima Health and the CalOptima Health MSSP provider will maintain the confidentiality of all member records and information.

APPEALS, GRIEVANCES AND COMPLAINTS PROCESS

- An MSSP member whose services have been denied, reduced, suspended or terminated 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 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 (TDD 800-952-8349).

- The MSSP provider will 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 them of their rights to file an appeal, grievance or complaint with the California Department of Social Services (CDSS) State Hearing Division.
- If a member disagrees with the MSSP provider's decision, they must complete and submit the Request for a State Hearing Form within 90 calendar days to the Office of the Chief Referee at CDSS.
- The MSSP provider retains 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's Grievance and Resolution Services (GARS) department will 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's LTSS department will be responsible for reporting MSSP appeals, grievances and complaints statistics and analysis to the LTSS Quality Improvement (QI) Subcommittee on a quarterly basis.

- When a member files a timely appeal of an MSSP provider's decision to terminate the member from the MSSP program or services, they are 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 will 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 will notify the member of the denial.
    4. If granted, CDSS will assign the appeal to an ALJ who will precede the State Hearing.
    5. Notify CalOptima Health GARS that an appeal was filed.

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

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

On a quarterly basis, the MSSP provider will submit a report of members' appeals, grievances and complaints to CalOptima Health's LTSS and GARS departments, 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 will communicate any non-MSSP-related appeals, grievances and complaints to GARS.
- GARS will communicate any MSSP-related appeals, grievances and complaints that are received internally to the MSSP provider.
- Upon receipt of a member's appeal, grievance or complaint, GARS will keep records using an internal tracking system, including 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

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

C6: LONG-TERM SUPPORT SERVICES (LTSS)

OVERVIEW

CalOptima Health administers the following LTSS:

- LTC as a Medi-Cal managed care plan benefit (**Section C4: Long-Term Care Service Referrals**)
- CBAS as a Medi-Cal managed care benefit
- MSSP as a Medi-Cal managed care plan benefit (**Section C5: Multipurpose Senior Services Program**)
- Initial referrals only for **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 nonmedical help

LTSS LIASION ROLES AND RESPONSIBILITIES

The role and responsibilities of the CalOptima Health LTSS liaison include, but are not limited to:

- Beginning in calendar year 2026, CalOptima Health must hold an "office hours" webinar at least once per calendar quarter for all eligible providers furnishing LTC services to present updates related to policies and procedures pertaining to LTC services and answer frequently asked questions.
    - The webinar must allow providers to participate virtually via telephone and optionally via an online teleconference service.
    - The webinar must provide the capability and opportunity for providers to ask live questions.
    - The LTSS liaison must publish the date and time of the webinar and instructions to join and notify all applicable providers at least 30 days prior to the webinar.
- Receive training on the full spectrum of rules and regulations pertaining to Medi-Cal-covered LTC, including resident rights under state and federal law, payment and coverage policies, prompt claims payment requirements, provider dispute resolutions policies and procedures, and care management, care coordination and Transitional Care Services policies.
- Serve as a single point of contact for service providers in both a provider representative role and to support care transitions, as needed.
- LTSS liaisons must assist service providers in addressing claims and payment inquiries in a responsive manner and assist with care transitions among the LTSS provider community to best support a member's needs.
- Notify providers of any changes to the LTSS liaison as soon as reasonably practical, but no later than the date of change, and must notify DHCS within five days of the change.

COMMUNITY-BASED ADULT SERVICES

CalOptima Health is responsible for determining CBAS eligibility and medical necessity criteria. CalOptima Health may receive an inquiry for CBAS from a variety of sources, including the CBAS center, a member or their authorized representative, a member's PCP or specialist, or a member's case manager or personal care coordinator. CalOptima Health 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, CalOptima Health's LTSS staff will process all CBAS benefit inquiries and CBAS authorization requests.

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:

- Be enrolled in CalOptima Health Medi-Cal or OneCare
- 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 a moderate to severe cognitive disorder, such as Alzheimer’s or other dementia
- Has mild cognitive impairment
- Has developmental disabilities that meet RC criteria and eligibility

CalOptima Health LTSS staff or a contracted registered nurse will perform a face-to-face (F2F) assessment of the member within 30 calendar days of receipt of the initial eligibility inquiry. CalOptima Health will not require an initial F2F review when adequate documentation is available to determine a member's eligibility for CBAS. CalOptima Health LTSS clinical staff will 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 NOA or Integrated Notice of Denial that addresses the member's right to file an appeal or grievance under state and federal law.

CBAS Authorization Process

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

- A completed CalOptima Health CBAS Authorization Request Form (ARF), including 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 IPC
- An authorization is required initially before a member attends CBAS and every six months thereafter

IN-HOME SUPPORTIVE SERVICES

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

Eligibility for IHSS

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

- Be disabled, blind or 65 years of age or older
- Be unable to live at home safely without help
- Be able to 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.

Responsibilities of the Social Services Agency

The County of Orange Social Services Agency (SSA) is responsible for verifying and processing IHSS applications. Once the IHSS application intake process is complete, the IHSS social worker will conduct an in-home, F2F assessment and determine whether to approve, modify or deny the application, including determining authorized hours.

Responsibilities of IHSS Public Authority (PA)

The IHSS PA is responsible for recruiting, training and maintaining IHSS providers/caregivers.

Responsibilities of LTSS IHSS Liaison

CalOptima Health must designate a person to serve as the day-to-day liaison with the county IHSS agency. CalOptima Health, in collaboration with the county IHSS agency, must ensure the liaison is sufficiently trained on referral processes and providers. The IHSS liaison functions may be assigned to the LTSS liaison if they meet the training requirements and have the expertise to work with the county IHSS liaison. The role and responsibilities of the CalOptima Health IHSS liaison include, but are not limited to:

- Coordinating with the county IHSS agency to ensure members do not receive duplicative services through ECM, Community Supports and other services
- Tracking all members receiving IHSS and continuing to coordinate services with the county IHSS agency for members until IHSS notifies CalOptima Health that IHSS is no longer needed for the member
- Identifying members receiving, referred to or approved for IHSS and conducting a reassessment of members' risk tier as part of the member's Health Risk Assessment (HRA)
- Continuing to provide basic population health management and care coordination of all medically necessary services while members receive IHSS (these are a function of the Utilization Management and Case Management departments)

IHSS ENROLLMENT FOR ONECARE MEMBERS

OneCare members are eligible for IHSS. Enrollment in OneCare is voluntary for IHSS members. Members may opt out of OneCare and choose not to have their Medicare benefits coordinated by CalOptima Health.

Interdisciplinary Care Team

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

Grievances and Appeals

CalOptima Health 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 regarding CBAS or IHSS services (initial referrals only), contact LTSS 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.

To apply for IHSS, members can 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, they 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 Children's Presumptive Eligibility (CPE) 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 CPE 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 CPE.

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 CPE 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 CPE 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 CPE 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 CPE 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, **CPE-certified providers** should send their CMS 1500 or UB04 form directly to:

   Medi-Cal/ CPE
   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.

For additional information regarding PPS, please visit the CalOptima Health website:
https://www.caloptima.org/ForProviders/Resources/ManualsPoliciesandGuides/PPSProviderResources.aspx

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 contracted providers, health networks, CalAIM services and other community supports/resources. PSS is available to pregnant members for the duration of their pregnancy and up to one year after birth (postpartum period). Services may include, but are not limited to:

- Referrals to Comprehensive Perinatal Services Program (CPSP) in-network providers
- Nutrition, health education, psychosocial assessments and other appropriate interventions
- Referrals to the Women, Infants and Children (WIC) program
- Information about breastfeeding and obtaining a breast pump
- Behavioral health services
- Other information regarding prenatal care or services

CalOptima Health relies on its providers to notify the health plan about pregnant women by submitting a Pregnancy Notification Report (PNR) form to CalOptima Health's Case Management (CM) department within five calendar days after a member's first obstetric visit.

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 CalOptima Health at **714-246-8677**.
3. To obtain more information about PSS, call CalOptima Health's Customer Service 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, including Non-Specialty Mental Health Services (NSMHS) for Medi-Cal members with mild to moderate impairments. 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, including lab work, drugs and supplies
- Outpatient services for the purposes of monitoring drug therapy
- Psychiatric consultation
- Substance use disorder services, including but not limited to, Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT); preventative screenings (tobacco, alcohol and drug use screenings); Medication-Assisted Treatment (MAT) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings; and emergency and post-stabilization services necessary to stabilize the member
- Transcranial magnetic stimulation (TMS)
- Dyadic services for children under 21 and their parents or caregivers

When members are determined to have a level of impairment other than mild to moderate, they will receive specialty mental health services (SMHS) directly from the Orange County Health Care Agency (HCA) Behavioral Health Plan (BHP), the county behavioral health agency or community-based organizations. These services may 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. To refer a CalOptima Health Medi-Cal member for SMHS, call the Orange County Beneficiary Access Line at 800-723-8641. This line is available 24/7.

Minors 12 years of age or older may consent to outpatient mental health treatment or counseling without consent from a parent or legal guardian if, in the opinion of the attending professional, the minor is mature enough to participate intelligently in the outpatient services.

Behavioral Health Services at Long-Term Care Facilities

Medi-Cal beneficiaries receiving LTC services 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 (BHT)

CalOptima Health covers BHT services under EPSDT. BHT services include 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
- Has a recommendation from a licensed physician, surgeon or licensed psychologist that evidence-based BHT services are medically necessary and covered under Medicaid
- Is medically stable and without need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities

Prior Authorization

Most Medi-Cal outpatient behavioral health services do not require prior authorization. Some services, including but not limited to TMS and BHT services, require prior authorization. Providers can refer to the CalOptima Health website for the most up-to-date information on behavioral health services that require prior authorization.

To request authorization for services, providers can use the CalOptima Health Provider Portal or 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 Request 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:

- Inpatient mental health services
- 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)
    - TMS)
    - Screenings, including but not limited to, SABIRT, Adverse Childhood Experiences (ACEs) and depression
    - Opioid Treatment Program (OTP) services

Prior Authorization

Many OneCare outpatient behavioral health services do not require prior authorization. Some services may require prior authorization, including, but not limited to, IOP, PHP, ECT, TMS and OTP. Providers can refer to the CalOptima Health website for the most up-to-date information on BH services that require prior authorization. To request authorization for services, providers can use the CalOptima Health Provider Portal or 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** (TTY **800-735-2929**) and choose the Medi-Cal option. Members will be connected to a CalOptima Health representative. The member will be screened for their 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 BHP. 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** (TTY **800-735-2929**) and choose the OneCare option**.** The member will be connected to a CalOptima Health representative to assist the member in obtaining appropriate services.

HOW TO MAKE A REFERRAL TO SUBSTANCE USE DISORDER SERVICES

Referrals to substance use disorder services may be initiated by the member, their PCP or their behavioral health provider. See Section D2 for details.

QUESTIONS FROM BEHAVIORAL HEALTH PROVIDERS

Medi-Cal and OneCare

Behavioral health providers who have questions about contracting, claims processing, open referrals or other administrative issues for the Medi-Cal and OneCare programs can contact the 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

MA.7020: Behavioral Health Services

This section applies to the following CalOptima Health programs:

Medi-Cal

C11: SUBSTANCE USE DISORDER SERVICES

CalOptima Health offers substance use disorder services to members, which include:

- SABIRT for members 11 years and older, including pregnant women.
- Preventive screenings including tobacco, alcohol, and illicit drug screenings for adults and children, conducted in accordance with USPSTF grade A and B recommendations and AAP Bright Futures recommendations
- Medications for Addiction Treatment (MAT) provided in primary care, inpatient hospitals, emergency departments and other contracted medical settings
- Emergency and post-stabilization services as necessary to stabilize the members

Members under 21 years of age are eligible for additional screening benefits under EPSDT. For additional details regarding the policy, please refer to the Medi-Cal Provider Manual. In providing substance use disorder (SUD) services, CalOptima Health must comply with all applicable laws and regulations relating to the privacy of SUD records, as well as state law concerning the right of minors 12 years of age and older 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 that a member has a need for substance misuse services, an appropriate referral can be made to community health care and social service programs with specialty treatment programs.

For more information regarding substance use disorder services , visit the Providers section on CalOptima Health's website.

HOW TO MAKE A REFERRAL TO SUBSTANCE USE DISORDER SERVICES

Both the member's PCP and behavioral health provider can make referrals to SUD services. To receive member information related to substance use 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: Substance Use Disorder 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 ensure that covered services provided through telehealth are rendered by qualified providers who are licensed in the State of California, are enrolled as a Medi-Cal provider and meet 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 being provided 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 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 the member 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 nonmedical 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 if one or more of the following criteria apply:
   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 a 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 nonmedical 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.

Covered Services

1. One initial visit
2. Up to eight additional visits at any time during the perinatal period
3. Support during labor and delivery, including labor and delivery resulting in a stillbirth, abortion or miscarriage
4. Up to two extended three-hour postpartum visits after the end of a pregnancy, with the standing recommendation issued by DHCS.
5. An additional nine visits during the postpartum period are available with a second recommendation from a licensed provider
6. 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.

Doula services are an integral component of CalOptima Health's comprehensive approach to maternal and infant health. These services align with CalOptima Health's commitment to enhance access to high-quality, culturally responsive care and to promote the health and well-being of birthing parents and their infants. Medical providers and hospitals are encouraged to integrate doulas as part of the interdisciplinary team, ensuring coordination of services and communication that supports the member's birth preferences.

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 disorders, 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, which can be in the core competencies or specialty area. The Supervising Provider must maintain evidence of this training. Supervising Providers may provide and/or require additional training, as identified by the Supervising Provider.

CHW Supervising Provider

A CHW Supervising Provider is an enrolled Medi-Cal provider 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, including the emergency department, an outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). CalOptima Health must not require Supervising Providers to have a licensed Provider on staff to contract with CalOptima Health to bill for CHW services.

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.

CalOptima Health and Health Networks must ensure that Supervising Providers or their Subcontractors contracting with or employing CHWs to provide covered CHW services to Members verify that CHWs have adequate supervision and training.

MEMBER ELIGIBILITY CRITERIA FOR CHW SERVICES

As of April 1, 2025, the DHCS Medical Director issued a statewide standing recommunication for CHW services, which can be found at https://www.dhcs.ca.gov/services/medi-cal/Documents/Standing-Recommendation-for-CHW-Services.pdf, removing the requirement for a written recommendation by a physician or other licensed practitioner of the health arts with their scope of practice under state law. DHCS has determined that Medi-Cal members who meet the defined eligibility criteria to receive CHW services as listed below would benefit from receiving up to six hours annually of Medi-Cal covered CHW services from a CHW

operating under the supervision of an enrolled Medi-Cal provider. CHWs who use this standing recommendation for Medi-Cal members should note the standing recommendation and the member's eligibility criteria in their records.

- 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.
- 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 within the previous six months, including when Medi-Cal members are in the emergency department.
- 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 service.
- Members released from incarceration within the past six months.

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.

CHW violence prevention services are specific to community Violence (e.g., gang violence). CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

The DHCS standing recommendation authorizes CHWs to provide covered Medi-Cal CHW services including health education, health navigation, screening and assessment, and individual support and advocacy, which can be reimbursed using established Current Procedural Terminology billing codes 98960-98962 and subject to all frequency and other policy requirements as outlined in Medi-Cal's policy, including a frequency limit of 4.0 units (2.0 hours) per day. Licensed providers are encouraged to develop a written plan of care when a need for multiple or ongoing CHW services is identified, and a written plan of care is required for continued CHW services after 12 units of care per Medi-Cal member in a single year from the initial date of service, which would constitute a new recommendation for more than the six hours authorized by this standing recommendation.

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.

PLAN OF CARE

For members who need multiple ongoing CHW services or continued CHW services after 12 units of services, except for services provided in the emergency department, 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 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.

Services may also be provided to a parent or legal guardian of a member under age 21 for direct benefit of the member, in accordance with a recommendation from a licensed provider. A service for the direct benefit of the member must be billed under the member's Medi-Cal ID. If the parent or legal guardian of the member is not enrolled in Medi-Cal, the member must be present during the session.

For CHWs that render street medicine, the Supervising Provider must bill CalOptima Health for any appropriate and applicable services within the scope of the CHW benefit.

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
- Transporting members
- Services provided to individuals not enrolled in Medi-Cal, except as noted above
- Services that require a license

Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as these are covered under the 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 of CHW services, are required to enroll as Medi-Cal providers, consistent with All Plan Letter (APL) 22-013: Provider Credentialing/Re-credentialing and Screening/Enrollment or any superseding APL, if there is a state-level enrollment pathway for them to do so.

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

Community-Based Organizations (CBOs) with CHWs offering Justice-Involved (JI) services and licensed/ unlicensed individuals rendering care management services may enroll through the CBO pathway. This option will be available to both first-time CBO applicants and currently enrolled CBO providers submitting a

supplemental application. Additionally, county children and families commissions will be eligible to apply for enrollment through the Local Health Jurisdictions (LHJs) and county children and families commissions that provide CHW and Asthma Preventative (AP) services.

CBOs, LHJs, and county children and families commissions must attest that all of their CHWs, for whom they will bill either DHCS or a managed care plan (MCP) contracted with DHCS for the delivery of CHW services provided to Medi-Cal members, meet the qualifications listed in the State Plan for CHWs. Additionally, the applicants must attest that they understand that DHCS may audit CHW qualifications and services provided and that the CBOs, LHJs, and county children and families commissions must supply documentation upon DHCS' request. This attestation does not supersede any of DHCS' authority to audit or request records from the provider pursuant to state and federal law and the provider agreement. CBOs, LHJs, and county children and families commissions must report the name of each individual providing CHW services in the application.

BILLING, CLAIMS AND PAYMENTS

CHW services must be reimbursed through a CHW Supervising Provider in accordance with its provider contract. 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

C15: RESPONSIBILITIES FOR INDIAN HEALTH CARE PROVIDERS (IHCP) AND AMERICAN INDIAN MEMBERS

Effective January 1, 2024, CalOptima Health is required to have an identified tribal liaison dedicated to working with each contracted and non-contracted IHCP in its service area as outlined in in Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members. The tribal liaison is responsible for coordinating referrals and payment for services provided to American Indian members who are qualified to receive services from an IHCP.

Federal law defines an individual as an "Indian" if the individual meets any of the following criteria:

- Is a member of a Federally recognized Indian tribe;
- Resides in an urban center and meets one or more of the four following criteria:
    - Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
    - Is an Eskimo or Aleut or other Alaska Native;
    - Is considered by the Secretary of the Interior to be an Indian for any purpose; or
    - Is determined to be an Indian under regulations issued by the Secretary of Health and Human Services.
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native

The CalOptima Health Contract defines "American Indian" as a member who meets the criteria for an "Indian" as defined in federal law. Federal law defines an IHCP as a health care program operated by:

- The Indian Health Service (IHS), which means the agency of that name within the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act (IHCIA) Section 601, 25 USC Section 1661;
- An Indian Tribe, which has the meaning given in the IHCIA Section 4(14), 25 USC Section 1603(14);
- A Tribal Organization, which has the meaning given in the IHCIA Section 4(25), 25 USC Section 1603(26);
- An Urban Indian Organization (otherwise known as a UIO), which has the meaning given in the IHCIA Section 4(29), 25 USC Section 1603(29)

Tribal Health Program means an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

AMERICAN INDIAN MEMBER RIGHTS AND PROTECTIONS

- American Indian Medi-Cal members are not required to enroll in a Managed Care Plan (MCP), except in County Organized Health Systems (COHS) such as CalOptima Health and Single Plan Model counties;

and that those who are voluntarily enrolled in an MCP in non-COHS and non-Single Plan Model counties are permitted to disenroll from the MCP without cause, even if their aid code is subject to mandatory managed care enrollment.

- American Indian Members can request to receive services from an IHCP and can choose an IHCP within the CalOptima Health's Network as a Primary Care Provider (PCP).
    - Currently, CalOptima Health does not have any IHCPs within CalOptima Health's service area of Orange County.
- American Indian members may obtain covered services from an out-of-network IHCP without requiring a referral from a Network PCP or Prior Authorization.
- American Indian members may receive services from an out-of-network IHCP even if there are in-network IHCPs available.
- IHCPs, whether in the CalOptima Health's network or out-of-network, can provide referrals directly to Network Providers without a referral from a Network PCP or Prior Authorization.
- American Indian members may request to receive services from an IHCP, if there is no in-network IHCP available, CalOptima Health will assist the member in locating and connecting with an out-of-network IHCP.
- American Indian members are not subject to enrollment fees, premiums, deductibles, copayments, cost sharing, or other similar charges. CalOptima Health is prohibited from imposing such fees or charges on any American Indian member who receives an item or service directly from an IHCP or through a referral to an IHCP, or reduce payments due to a Provider, including an IHCP, by the amount of any enrollment fee, premium, deductible, copayment, cost sharing, or similar charge.

IHCP RIGHTS AND PROTECTION

- CalOptima Health will ensure that the IHCP, providing Medi-Cal covered services, including transportation, to an American Indian member, is enrolled in the Medi-Cal Program.
- CalOptima Health must inform the IHCP about the following reimbursement provision if contacted by an IHCP regarding enrollment.
    - An IHCP facility must enroll through the state-level enrollment pathway in order to receive reimbursement at the All-Inclusive Rate (AIR) or Prospective Payment System (PPS), and to receive Medi-Cal FFS reimbursement for CalOptima Health carved-out-services, such as dental services
- CalOptima Health cannot apply any requirement that a Tribal Health Program, including an Indian Health Service or Tribal Federally Qualified Health Center provider, be licensed.
- CalOptima Health will alert an IHCP to the DHCS enrollment time frames and processing requirements when directing them to enroll through DHCS.
- CalOptima Health must ensure that providers who provide services at an IHCP facility are enrolled in Medi-Cal as an Ordering, Referring, and Prescribing (ORP) Provider.
- CalOptima Health will not require the licensure of a health professional employed by a Tribal Health Program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state.
- IHCP does not have to contract with CalOptima Health as a Network Provider, nor does the IHCP have to contract with any Subcontractor, in order to be reimbursed by either CalOptima Health or the Subcontractor for services provided to an American Indian Member.
- CalOptima Health must attempt to contract with each IHCP in its service area and submit documentation to DHCS of all efforts to contract with IHCPs, including as applicable, why CalOptima Health is unable to contract with an IHCP in its service area.
    - As noted above, CalOptima Health does not have any IHCPs within CalOptima Health's service area of Orange County.

  - CalOptima Health must include IHCP data in the CalOptima Health's 274 file submission to demonstrate compliance with Network requirements.
- Within 15 days of receiving a Network Provider application submitted by an IHCP, CalOptima Health will provide acknowledgement of receipt in a written notice to the IHCP.
- CalOptima Health's contracts with IHCPs cannot be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law; including the requirements as outlined in the "Other IHCP Contracting Requirements" subsection of APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members.
- CalOptima Health is required to ensure that IHCPs contracting as Network Providers are properly credentialed and re-credentialed, in accordance with the CalOptima Health Contract with DHCS and APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment, or any subsequent updates.
  - CalOptima Health must conduct site reviews of their contracted PCP sites, including IHCPs that are PCPs in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review, or any subsequent updates.
- CalOptima Health must provide payment of claims to IHCPs in a timely and expeditious manner in accordance with federal and state law and APL 23-020: Requirements for Timely Payment of Claims.
  - IHCP does not need to have a contract with CalOptima Health in order to receive reimbursement for services provided to an American Indian member.
  - Additionally, CalOptima Health is not permitted to deny claims submitted by an IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.
- CalOptima Health will reimburse an IHCP in accordance with the federal standard of payment, which includes payment of 90% of all clean claims (i.e., claims that require no additional information) within 30 calendar days of receipt, and payment of 99% of all clean claims within 90 calendar days of receipt.
- Tribal Health Programs, including Indian Health Service-Memorandum of Agreement and Tribal Federally Qualified Health Centers, are to be reimbursed at the federally established All-Inclusive Rate as noted in APL 17-020: American Indian Programs and APL 21-008: Tribal Federally Qualified Health Center Providers.
- Urban Indian Organizations, enrolled in Medi-Cal as a Federally Qualified Health Center, are to be reimbursed through the Prospective Payment System (PPS) methodology.
- CalOptima Health or Subcontractor will reimburse an IHCP that is enrolled in the Medi-Cal program for transporting an American Indian member to an IHCP, regardless if the IHCP is contracted with CalOptima Health or Subcontractor.
- If an IHCP provides transportation services to non-American Indian members, the IHCP must be enrolled in the Medi-Cal program as a transportation provider and must contract with CalOptima Health and/or CalOptima Heath's delegated transportation provider.
- CalOptima Health will provide reimbursement for transportation related travel expenses as described in 42 CFR section 440.170(a)(1) and (3), and APL 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses, or any subsequent updates.

CALOPTIMA HEALTH TRIBAL LIASION ROLES AND RESPONSIBILITIES

The role and responsibilities of the CalOptima Health tribal liaison include, but are not limited to:

- Providing information to IHCPs regarding enrollment and disenrollment of American Indian members;
- Coordinating care with in- and out-of-network IHCPs for American Indian members;

- Ensuring access to care with in- and out-of-network IHCPs for American Indianm;
- Providing assistance to IHCPs and American Indian Members with accessing appropriate transportation given logistical and geographical barriers unique to tribal communities;
- Providing case management for American Indian Members that involves in- and out-of-network IHCPs;
- Assisting IHCPs with provider relations services, claims and payment assistance and resolution, and member services;
- Providing support in obtaining grievance, appeal, and State Hearing services to IHCPs in cases that impact American Indian members;
- Providing benefits and services navigation and coordination, such as those for Foster Care, Community-Based Adult Services, Enhanced Care Management, Community Supports, Behavioral Health, Health Education, Home and Community Based Services, California Children's Services (CCS), etc., for IHCPs in order to provide full-spectrum services to American Indian members;
- Assisting internal liaisons in instances that involve IHCPs and/or American Indian Members and the other liaison's respective services and program, in particular the Foster Care liaison given the observed disproportionate representation of American Indian youth in the Foster Care system; as well as the liaisons for Long-Term Services and Supports, Transportation, CCS, Regional Center, Dental, and IHSS;
- Providing assistance to IHCPs regarding Medi-Cal program Provider enrollment and contracting, credentialing, and Facility Site Reviews; and
- Attesting to the completion of the Cultural Humility training from the California Governor's Office of the Tribal Advisor, the Overview of Trauma-Informed Care and Historical Trauma training from the IHS, and other relevant trainings as they are developed and noted by DHCS.

Additionally, DHCS strongly encourages CalOptima Health tribal liaisons to commit to the following activities to enhance relationships between CalOptima Health, IHCPs, and American Indian members:

- Providing assistance to the CalOptima Health's Member Services department in situations involving American Indian members;
- Representing CalOptima Health and providing assistance to Subcontractors to address inquiries and/or instances involving American Indian members;
- Participating in the CalOptima Health Member Advisory Committee and other CalOptima Health committees that potentially impact American Indian members;
- Attending and participating in tribal consultations involving tribes within CalOptima Health's service area;
- Attending and participating in DHCS' Tribal and Designees of Indian Health Programs Quarterly Meeting, and other relevant meetings;
- Developing tribal specific outreach and educational materials;
- Hosting marketing events and developing marketing materials focused on tribal health as permitted;
- Collaborating with other Managed Care Plan (MCP) tribal liaisons to discuss best practices, lessons learned, and sharing of information and resources;
- Collaborating with local tribal communities on the development of regional and culturally appropriate trainings for staff; and
- Having knowledge and consideration of Indigenous Determinants of Health when determining quality metrics and data reporting.

This section applies to the following CalOptima Health programs:

Medi-Cal

C16: COUNTY CHILD WELFARE LIAISON

Effective January 1, 2024, the Department of Healthcare Services (DHCS) requires CalOptima Health to designate at least one (1) individual to serve as the county child welfare liaison to ensure the needs of members involved with child welfare and foster care are met. CalOptima Health must also designate an appropriate number of staff to serves as the child welfare liaisons to meet the health care needs of children and youth involved in child welfare in Orange County, CA. Additional child welfare liaisons may be designated as needed to ensure the healthcare needs of children and youth involved in child welfare are met and should be commensurate to the number of members involved in child welfare enrolled in CalOptima Health. CalOptima Health is expected to fulfill the child welfare liaison role with adequate staffing, and to reassess staffing levels at regular intervals, to ensure effectiveness and ability to serve children and youth involved in child welfare and the geographical landscape of the Orange County, CA. service area. CalOptima Health is responsible for ensuring subcontractor's compliance with the requirements outlined in APL 24-013: Managed Care Plan Child Welfare Liaison.

CalOptima Health's county child welfare liaisons will follow the DHCS-issued standards and expectations as set forth in All Plan Letters (APLs) or other similar instructions. The role and responsibilities of the child welfare liaison include, but are not limited to:

- Coordinates care on behalf of children and youth involved in child welfare to ensure the health care needs are met.
- Serves as a leader within CalOptima Health to advocate on behalf of children and youth involved in child welfare by serving as a point of escalation to identify and resolve systematic and operational obstacles for accessing services.
- Serves in an administrative role by providing assistance and resources to CalOptima Health staff, providers, county child welfare staff, and other staff responsible for the member's care coordination, including Enhanced Care Management (ECM) Lead Care Managers for the Children and Youth Involved in Child Welfare Population of Focus and county child welfare staff, such as Health Care Program for Children in Foster Care public health nurses, and other staff.
- Is not intended to duplicate care coordination activities provided by members by other providers and staff members, but rather to support and act as a resource to solve escalated issues regarding CalOptima Health Services as they arise.

Additional roles and responsibilities include, but are not limited to:

1. Act as a resource and provide technical assistance for staff involved in the coordination of the member's care to ensure escalated issues are resolved; in CalOptima Health's covered services, including Medically Necessary Early and Periodic Screening Diagnostic and Treatment (EPSDT) services (Medi-Cal Kids & Teens), are closely coordinated with other Medi-Cal programs that are carved-out from CalOptima Health, such as Specialty Mental Health Services as well as other non-Medi-Cal services and benefits, such as County Child Welfare Services overseen by the California Department of Social Services. Individuals who may request assistance from the CalOptima Health Child Welfare Liaison may include, but are not limited to:
    a. The member's designated ECM Lead Care Manager who is responsible for coordinating all aspects of ECM and Community Supports as part of the members multi-disciplinary care team. The ECM Lead Care Manager serves as the primary point of contact for the member and/or

parent, caregiver, legal guardian, resource parents, and other family member(s) and/or authorized support person(s) and coordinates with other staff responsible for coordinating the member's care and the CalOptima Health Child Welfare Liaison, as needed.

b. County child welfare staff and other county staff responsible for coordinating the Member's care including, but not limited to:
    i. County foster care public health nurses;
    ii. County probation officers;
    iii. County child welfare social workers;
    iv. County behavioral health providers;
    v. Community Health Workers (CHWs);
    vi. County Health Education specialists;
    vii. CalOptima Health providers; and
    viii. Other county child welfare staff and/or secondary case managers, as applicable.
c. Other staff who may be responsible for coordinating the member's care, including but not limited to:
    i. CalOptima Health Providers;
    ii. Indian Health Care Providers;
    iii. Tribes, in the case of an American Indian member;
    iv. Community Health Workers;
    v. Regional Center staff; and
    vi. Other secondary case managers and/or service providers, as appliable.
d. County Liaisons as defined in the Memorandum of Understanding (MOU) between CalOptima Health and county child welfare agencies, as the county's designated point of contact responsible for acting as the liaison between the county and CalOptima Health. In accordance with the MOU between CalOptima Health and county child welfare agencies and CalOptima Health contract, CalOptima Health must notify the other party, for which they are serving as a liaison, of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) days of the change.

2. Serve as a point of escalation for CalOptima Health staff, providers, and county child welfare staff to resolve issues in a timely manner when members are experiencing difficulty accessing services, obtaining referrals, changing providers, or facing operational obstacles to receiving health care services
    a. For example, the CalOptima Health Child Welfare Liaison must assist county child welfare staff in navigating the health care system on behalf of members involved in child welfare by assisting with obtaining needed services and supports when they are experiencing delays, or when they need help selecting an appropriate Primary Care Provider (PCP).
3. Collaborate with the CalOptima Health ECM staff to ensure that all children and youth involved with child welfare that are eligible for the ECM benefit are offered and/or enrolled into the ECM program and help establish referral pathways with the entities listed above who are serving these children and youth.
4. Provide resources and support to CalOptima Health staff, providers and county child welfare staff about member enrollment and disenrollment when they are made aware that the member will move to a different county. Support may include providing information about how to report a change of address to county social services departments and how to contact the Medi-Cal Managed Care Ombudsman as needed to expedite disenrollment from CalOptima Health in the county from which the member is leaving.
5. Assist CalOptima Health staff, providers, and county child welfare staff with benefits and services navigation and coordination, including but not limited to ECM, Community Supports, Behavioral Health, Transitional Care Services, Health Education, Home and Community Based Services, California Children's Services (CCS), and tribal health care, etc., to provide full-spectrum services to members.

6. Coordinate with other internal CalOptima Health liaisons related to specific member populations and services or programs (e.g., liaisons for Long-Term Services and Supports, Transportation, CCS, Regional Center, Dental, and In-Home Supportive Services)
    a. In particular, the CalOptima Health Liaison must coordinate with the designated tribal liaison for members who are American Indian children and youth involved in child welfare.
    b. This is particularly important in light of the disproportionate representation of American Indian children and youth involved in child welfare.
7. If applicable, coordinate with the designated CalOptima Health County Liaison, which serves as the CalOptima Health designated point of contact via the MOU between the CalOptima Health and county child welfare agencies. The CalOptima Health County Liaison and the CalOptima Health Child Welfare Liaison roles may be the same individual.
8. Attend quarterly meetings with local county child welfare agencies as required by APL 23-029, including subsequent updates, and as outlined in the MOU between the CalOptima Health and county child welfare agencies, to address care coordination, quality improvement activities, quality improvement outcomes, systemic and case-specific concerns, and communicating with others within their organizations about such activities.
9. Participate in and provide input for quality improvement activities associated with the MOU between CalOptima Health and county child welfare agencies.
10. As applicable, pursuant to the MOU between the CalOptima Health and county child welfare agencies, collaborate with the CalOptima Health County Liaison to ensure compliance with the training and education provisions of the MOU, which includes providing training and/or educational materials to county child welfare agencies on how CalOptima Health's Covered Services, and any carved-out services, may be accessed, including during nonbusiness hours.
11. Provide resources and support to CalOptima Health staff and Providers in understanding the Foster Youth Bill of Rights.
12. Support CalOptima Health staff and providers to use trauma-informed approaches when interacting with children, youth/non-minor dependents, parents, family members, legal guardians, or caregivers.

Additionally, DHCS strongly encourages CalOptima Health County Child Welfare Liaisons to commit to the following activities to enhance relationships between CalOptima Health and county child welfare agencies for members involved in child welfare:

- Participate in the CalOptima Health Community Advisory Committee and other CalOptima Health committees and meetings that potentially impact members involved in child welfare and foster care.
- As applicable, collaborate with the county to identify opportunities for coordination of and alignment with the county's Interagency Leadership Team's efforts in implementing the AB 2083 SOC MOU, and participate in the SOC Local Interagency Leadership Team meetings to which CalOptima Health may be invited.
- Collaborate with other CalOptima Health County Child Welfare liaisons internally and with CalOptima Health County Child Welfare Liaisons in other Managed Care Plans (MCPs) to discuss best practices, lessons learned, and sharing of information and resources.

CalOptima Health must designate individuals for the child welfare liaison position who can competently fulfill their roles and responsibilities as outlined above. CalOptima Health child welfare liaisons must meet the following criteria:

- Have expertise, demonstratable experience, or sufficient training in the following:
    - Child welfare services and county behavioral health services.

  - County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes.
  - Trauma informed care practices.

Additional expertise, experience, and training CalOptima Health may consider including, but are not limited to:

- Having a master's degree and/or other additional training in social work, public health nursing, or another related field.
- Having familiarity with Medi-Cal enrollment and disenrollment processes, as well as county social services agency processes for updating addresses and other eligibility information.
- Having experience or training in coordinating care within child welfare services and juvenile justice systems and have an understanding of the Foster Care Bill of Rights.

CalOptima Health is responsible for ensuring subcontractor's compliance with the requirements outlined in APL 24-013: Managed Care Plan Child Welfare Liaison.

This section applies to the following CalOptima Health programs:

Medi-Cal

C17: ENHANCED CARE MANAGEMENT

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to select populations of focus that addresses the clinical and non-clinical needs of the highest-utilizing members through intensive coordination of health and health-related services. ECM meets members wherever they are — on the street, in a shelter, in their doctor's office or at home. Members have a single lead care manager who will coordinate care and services among the physical, behavioral, dental, developmental and social services delivery systems, making it easier for the member to get the right care at the right time. ECM focuses on the following member populations:

- Individuals and families experiencing homelessness
- Adults and children/youth at risk for avoidable hospital or emergency department utilization (formerly "High Utilizers")
- Adults and children/youth with serious mental illness or substance use disorder needs
- Adults and children/youth transitioning from incarceration
- Adults living in the community and at risk for long-term care institutionalization
- Adults nursing facility residents transitioning to the community
- Children and youth enrolled in California Children's Services (CCS) or CCS Whole-Child Model (WCM) with needs beyond the CCS condition
- Children and youth involved in child welfare (including those with a history of involvement in welfare and foster care up to age 26)
- Adults and children/youth birth equity population of focus

ECM is a whole-person interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs. Members are assigned an ECM lead care manager (LCM) who provides high-touch, community-based, comprehensive care management and care coordination. For more detailed information, please see the Department of Health Care Services' (DHCS) CalAIM Enhanced Care Management Policy Guide.

CalOptima Health covers ECM services for members with highly complex needs by coordinating primary and preventative care, acute care, behavioral health care, developmental health care, oral health care, community-based long-term services and supports (LTSS) and referrals to community resources. CalOptima Health's delegated health networks currently serve as CalAIM ECM providers and are responsible for providing the seven core components of ECM services:

1. Outreach and engagement
2. Comprehensive assessment and care management
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family support services
7. Coordination and referral to community and social supports

ECM providers serving the justice-involved (JI) population of focus will meet not only the standard ECM provider requirements but also requirements outlined in the JI Policy and Operational Guide for Planning and Implementing the Justice Involved Initiative, including, but not limited to:

1. Meeting the following criteria pertaining to participation in pre-release care management services and warm handoffs:

    a. If the correctional facilities in the ECM provider's county of operation leverage an in-reach care management model, CalOptima Health must ensure that JI ECM providers offer pre-release care management services as in-reach care management providers and continue to serve the member post-release as the member's ECM provider.

    b. If the correctional facilities in the ECM provider's county of operation leverage an embedded care management model, CalOptima Health must ensure that the ECM provider participates in a warm handoff with the pre-release embedded care manager and the member.

2. ECM providers must bill fee-for-service (FFS) for all pre-release care management services and warm handoffs by either enrolling in the Provider Application and Validation for Enrollment (PAVE) system or contracting with the correctional facility to provide services billed under the correctional facility's National Provider Identifier (NPI).

Stopping ECM Services

Being a part of ECM is a Member's choice. If a Member would like to stop ECM at any time, they can inform their ECM provider or call CalOptima Health Customer Service toll-free at **1-888-587-8088** (TTY **711**) Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language.

Changing ECM Provider and/or Lead Care Manager

A Member can change their ECM provider and/or Lead Care Manager at any time by informing their ECM provider or calling CalOptima Health Customer Service toll-free at **1-888-587-8088** (TTY **711**) Monday through Friday, from 8 a.m. to 5:30 p.m. CalOptima Health has staff who speak their language.

CalOptima Health Policies and Procedures:

GG. 1353: CalAIM Enhanced Care Management Service Delivery

GG. 1354: CalAIM Enhanced Care Management – Eligibility and Outreach

GG. 1356: CalAIM Enhanced Care Management Administration

This section applies to the following CalOptima Health programs:

Medi-Cal

C18: COMMUNITY SUPPORTS

Community Supports improve the health and well-being of CalOptima Health Members by addressing Members' health-related social needs and helping them live healthier lives and avoid higher, costlier levels of care. Time-limited coverage of these housing-related Community Supports is intended to help Members experiencing or at risk of homelessness address their health-related social needs, support their transition to housing stability, and realize the significant improvements in health that have been shown to result from stable housing. Community Supports—with the exception of Transitional Rent—are optional for CalOptima Health to offer and for Members to utilize. The following benefits include:

- **Housing Transition Navigation Services (HTNS)** — Assist Members with finding, applying for, and obtaining housing. The services provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan.

- **Housing Deposits** — Assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household. The services and goods provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan.

- **Housing Tenancy and Sustaining Services (HTSS)** — Help a Member maintain safe and stable tenancy once housing is secured. The services provided to a Member must be based on an individualized assessment of needs and documented in the Member's housing support plan.

- **Transitional Rent –** Beginning January 1, 2026, Transitional Rent will be the newest addition to the suite of Community Supports to support Members experiencing or at risk of homelessness covered under Medi-Cal. Transitional Rent provides up to six months of rental assistance in interim and permanent settings to Members who are experiencing or at risk of homelessness, have certain behavioral health clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

  CalOptima Health offers Transitional Rent in limited circumstances and is designed to support housing stability for eligible members, which will be offered to members who meet the behavioral health population of focus clinical risk factor (meet access criteria for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or DMC-Organized Delivery System and are experiencing or at risk of homelessness.

  Member's authorized for Transitional Rent are automatically determined eligible for ECM Services and the appropriate Housing Trio (Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining) service(s).

  Members will be presented with transition pathways and available resources to both Medi-Cal housing subsidies and supports such as the Behavioral Health Services Act and non-Medi-Cal housing subsidies and supports such as 211 Orange County and United Way Orange County. 211 Orange County and the United Way Orange County can assist in accessing Orange County's CES/HMIS system, to create a path to permanent stable housing when Members are transitioning out of Transitional Rent. Members may dial 2-1-1 or 949-646-4357 to be connected to a referral specialist.

- **Short-Term Post Hospitalization** — Provides Members who are exiting an institution and experiencing or at risk of homelessness with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting the institution. This would include recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder or mental health treatment facility, correctional facilities, or nursing facilities.

- **Recuperative Care (Medical Respite)** — Also referred to as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including a behavioral health condition). A stay in a Recuperative Care setting allows an individual to recover from an injury or illness while also obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food, and housing. It is for individuals who have medical needs significant enough to result in emergency department (ED) visits, hospital admissions, or other institutional care.

- **Respite Services** — Are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

- **Day Habilitation Programs** — Are designed to assist a Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The service is provided in a Member's home or an out-of-home, non-facility setting. The services are often considered peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision.

- **Assisted Living Facility (ALF) Transitions** — (formerly known as "Nursing Facility Transition/Diversion to Assisted Living Facilities such as Residential Care Facilities for the Elderly and Adult Residential Facilities") is designed to assist individuals with living in the community and avoid institutionalization, whenever possible. The goal of the service is to facilitate nursing facility transition back into a home-like, community setting, and/or to prevent nursing facility admissions for Members living in the community. This Community Support is intended for Members with an imminent need for nursing facility level of care (LOC) and is intended to provide a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility.

- **Community or Home Transition Services** — (formerly known as "Community Transition Services/Nursing Facility Transition to a Home") helps individuals to live in the community and avoid further institutionalization in a nursing facility. Community or Home Transition Services support Members in transitioning from a licensed nursing facility to a living arrangement in a private residence or public subsidized housing where the Member is responsible for identifying funding for their living expenses. This service also covers set-up expenses necessary for a Member to establish a basic household.

- **Personal Care and Homemaker Services (PCHS)** — Can be provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services as similarly provided by the In-Home Supportive Services (IHSS) program, including house cleaning, meal

preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. PCHS aid individuals who could otherwise not remain in their homes.

- **Environmental Accessibility Adaptions (Home Modifications)** — (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

- **Medically Tailored Meals (MTMs)/Medically Supportive Food (MSF)** — are designed to address individuals' chronic or other serious conditions that are nutrition-sensitive, leading to improved health outcomes and reduced unnecessary costs.

- **Sobering Center** — Are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are experiencing homelessness or those with unstable living situations, with a safe, supportive environment to become sober.

- **Asthma Remediation** — Can prevent acute asthma episodes that could result in the need for emergency services and hospitalization. The Asthma Remediation Community Support consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a Member, or to enable a Member to function in the home with reduced likelihood of experiencing acute asthma episodes.

Members can access Community Support Services by requesting a referral through self-referral, referral by a health care provider, or a referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at https://www.caloptima.org/en/health-insurance-plans/medi-cal/benefits-and-services/community-supports#Flyers.

For additional information, please visit the Community Supports page on CalOptima Health's website, www.caloptima.org.

CalOptima Health Policies and Procedures:

GG. 1355: CalAIM Community Supports

This section applies to the following CalOptima Health programs:

Medi-Cal

C19: TRANSPLANT

CalOptima Health's Transplant Program

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

CalOptima Health is responsible for reviewing and authorizing requests for transplant evaluations and all covered services related to transplants. CalOptima Health's Utilization Management and Case Management will coordinate with the authorized Center of Excellence (COE) to address the members' transplant and transplant-related needs. If necessary, CalOptima Health's Utilization Management completes facility transfers for transplant needs to ensure timely transfers.

While the member is evaluated pending listing, the member's health network remains responsible for addressing all other utilization management and case management needs.

Who Qualifies for Transplant Coverage

Transplants are covered under Medi-Cal if:

1. The transplant is performed at a DHCS-approved transplant COE.

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.

Once listed, transplant members 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 CHCN 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-contracted HMO, PHC or shared-risk health network, the provider should contact the member's health network immediately. The members' health network will work with CalOptima Health to identify an appropriate transplant center and transition the member as needed.

If a provider identifies a member who may need a transplant and is enrolled in COD or CHCN, the provider can contact CalOptima Health by submitting a request for services through the provider portal or faxing an Authorization Request Form for urgent requests to **714-338-3137** and routine requests to **714-246-8579**.

POST TRANSPLANT

After 365 days, members can select a new health network or remain with COD or CHCN.

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:

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 Medi-Cal beneficiaries who reside in Orange County.

Services include outpatient drug-free treatment, 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 primary care provider (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 Orange 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. 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 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 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 intestinal 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 [CHCN]).

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 CHCN).

HELPFUL INFORMATION FOR THE AUTHORIZATION PROCESS

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

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 discontinues it 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

- 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: 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: 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**.

CALIFORNIA CHILDREN'S SERVICES LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must designate at least one individual to serve as the CCS liaison. They will be the primary point of contact responsible for CCS members' care coordination. CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS children.

CLAIMS INFORMATION

Claims for WCM services should be submitted to the member's health network (including COD or CHCN), 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/health-insurance-plans/medi-cal/benefits-and-services
or by calling **714-347-0300** (CalOptima Health providers only).

Health Network	Phone Number
AltaMed Health Services – AHN AltaMed Health Services	855-848-5252
AMVI Care Health Network	888-747-2684
CalOptima Health Community Network	**714-246-8600**
Children's Hospital Orange County Health Alliance	800-424-2462
Family Choice Health Services Family Choice Medical Group	800-611-0111
Heritage Provider Network – Regal Medical Group	844-292-5173
Noble Mid-Orange County	888-880-8811
Optum	888-656-7523
Prospect Medical Group	833-303-4551
Providence	855-359-6323

United Care Medical Group	877-225-6784

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

This section applies to the following CalOptima Health programs:

Medi-Cal

D4: DENTAL SERVICES

The 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 to undergo a medical surgery
- 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 Medi-Cal Dental 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 nondental 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 may also access dental services through Medi-Cal Dental. When available, additional dental services will be listed in the OneCare summary of benefits.

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

DENTAL LIASION ROLES AND RESPONSIBILITIES

CalOptima Health has an identified liaison available to Medi-Cal Dental providers to assist with referring members to other covered services. Other covered services include, but are not limited to, laboratory services and preadmission physical examinations required for admission to an outpatient surgical service center or an inpatient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). The role and responsibilities of the dental liaison include, but are not limited to:

- Ensuring that dental screenings and oral health assessments are included for all members
- Ensuring that all members are given referrals to appropriate Medi-Cal Dental providers
- Coordinating and providing medically necessary FRADS, fluoride varnish and dental services that may be performed by a medical professional
- For members less than 21 years of age, CalOptima Health must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the member's first tooth or at 12 months of age, whichever occurs first
- Ensuring the provision of medically necessary dental-related covered services that are not exclusively provided by dentists or dental anesthetists

CalOptima Health may require prior authorization for medically necessary covered services needed in support of dental procedures. If CalOptima Health requires prior authorization in support of dental procedures, CalOptima Health must develop and publish the policies and procedures for obtaining prior authorization for dental services to ensure they are provided to the member in a timely manner. CalOptima Health must coordinate with DHCS' Medi-Cal Dental Services Division in the development of its policies and procedures pertaining to prior authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

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 nonprofit agency under contract with the California Department of Developmental Services that serves people of all ages with developmental disabilities. In addition to meeting eligibility criteria, to qualify for services through the Regional Center of Orange County, the individual must reside in Orange County.

Who Is Eligible to Participate in RCOC?

Infants and toddlers (birth to 36 months) who are at risk of having developmental disabilities or who have a developmental delay may qualify for services. The criteria for determining the eligibility of infants and toddlers are specified in Section 95014 of the California Government Code as at least one of the following:

- A developmental delay of at least 25% in one or more areas of:
  - Cognitive
  - Communication
  - Social or emotional
  - Adaptive
  - Physical and motor development, including vision and hearing
- An established risk condition of known etiology, with a high probability of delayed development
- A high risk of having a substantial developmental disability due to a combination of biomedical risk factors

In addition, individuals at risk of having a child with a developmental disability may be eligible for genetic diagnosis, counseling and other prevention services.

For more information regarding Early Start eligibility criteria, please visit www.rcocdd.com/client-services/intake/early-start/

Regional Center Lanterman (age 3 and older) eligibility criteria are defined by law in Section 4512 of the California Welfare and Institutions Code.

Diagnoses that may qualify a person for Regional Center services include the following developmental disabilities:

- Autism
- Cerebral palsy
- Intellectual disability
- Epilepsy
- Conditions closely related to, or that require treatment, for an intellectual disability

In addition, to qualify for Regional Center services, a person's developmental disability must:

- Originate prior to age 18
- Be expected to continue indefinitely
- Be a substantial disability as defined by Title 17, Section 54001 of the California Code of Regulations, meaning the person experiences significant limitations in three or more of the following areas:

- Self-care
- Language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self-sufficiency

This definition does not include any handicapping condition that is solely psychiatric, a learning disability or physical in nature.

For more information regarding Lanterman eligibility criteria, please visit www.rcocdd.com/client-services/intake/lanterman/

What Types of Services Are Available Through 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)
- Social and recreational services
- Coordinated family support services

Medical, dental, psychiatric, psychological and behavioral services, in addition to DME and supplies, are primarily the responsibility of the individual's health plan. The regional center may consider funding in limited situations where the need is related to their regional center-eligible condition, and services are not otherwise available.

REGIONAL CENTER (RC) LIASION ROLES AND RESPONSIBILITIES

CalOptima Health must designate its own liaison to coordinate with each RC operating within CalOptima Health's service area. The role and responsibilities of the RC liaison include, but are not limited to:

- Assisting members with developmental disabilities in understanding and accessing services
- Acting as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10)
- Referring members with development disabilities to RCs for evaluation and access to nonmedical services provided by the RC, including, but not limited to, respite, out-of-home placement and supportive living
- Having a Memorandum of Understanding (MOU) in place as required in Exhibit A, Attachment III, Section 5.6 (MOUs with Local Government Agencies, County Programs, and Third Parties) to coordinate services for the member with RC staff to ensure the nonduplication of services
- Creating the individual developmental services plan required for all members with developmental disabilities, which includes identification of the member's medical needs and the provision of medically

necessary services such as medical care, non-specialty mental health services (NSMHS) and behavioral health treatment (BHT)
- Maintaining policies and procedures to identify and refer eligible members to the Home and Community Based Services (HBCS) program administered by the Department of Developmental Services (DDS)

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 Intake Department by calling 714-796-5100. To obtain more information, visit RCOC's website at 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 immigrants 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:

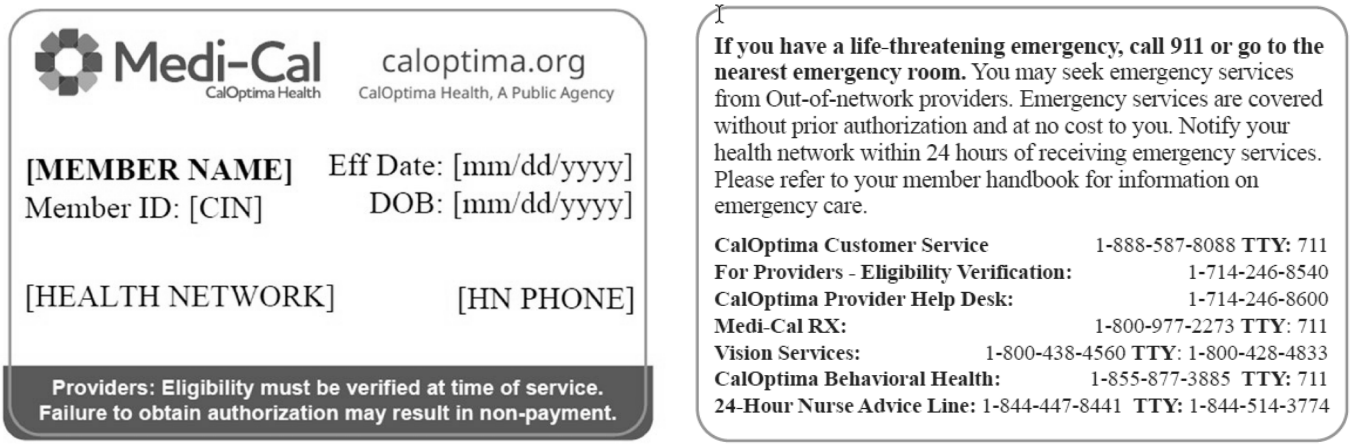
Medi-Cal, OneCare (HMO D-SNP), a Medicare Medi-Cal Plan

E3: CALOPTIMA HEALTH'S MEDI-CAL, ONECARE

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

- 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**
  d. Phone numbers for both pharmacy and vision services (card can be used for pharmacy and vision services)

Upon presentation of the CalOptima Health member ID card, a provider can verify the member's eligibility by using 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 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. Name of member's PCP
d. Phone number of member's PCP
e. Member's health network
f. Phone number of member's health network
g. 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 the 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 staff (nurses and medical directors) 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 or telephone, depending on the urgency of the requested service.

HOW TO REQUEST AUTHORIZATION FOR SERVICES

1. The provider should first verify the member's eligibility with CalOptima 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 CalOptima Health Community Network (CHCN), see steps 3–5 below.

3. For COD and CHCN 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. **Nonurgent 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:** Seven calendar 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 42 CFR § 438.210(d)(2)(i), 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 of 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, 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 and CalOptima Health Community Network Providers

GG.1508: Authorization and Processing of Referrals

This section applies to the following CalOptima Health programs:

OneCare

F1: OBTAINING AUTHORIZATION FOR MEDICAL SERVICES

CalOptima Health and its health networks perform 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 staff (nurses and medical directors) 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.

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 COD, the provider will submit the request for authorization to the CalOptima Health Utilization Management department by mail, fax or telephone, depending on the urgency of the requested service.

HOW TO REQUEST AUTHORIZATION FOR SERVICES

1. The provider should first verify the member's eligibility with CalOptima Health. 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 CHCN, see steps 3–5 below.

3. For COD and CHCN 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 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 **714-571-2440**. 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 **714-571-2440**.
    c. For retroactive authorizations, fax to **714-571-2440**.

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, www.caloptima.org.
- **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 could seriously jeopardize the member's life or health or ability to maintain or 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 **714-571-2440**
b. For routine requests, fax to **714-571-2440**
c. For retroactive authorizations, fax to **714-571-2440**

6. Please note that referrals to noncontracted or out-of-network providers must be approved by the appropriate UM 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 health network 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.

The following services do not require prior authorization:

- Emergency services
- Urgent care visits
- 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 and CalOptima Health Community Network 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 a referral 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 or fax the ARF to CalOptima Health's 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 noncontracted medical providers or facilities will be approved only when the requested services are not available within the contracted network.
4. Medical second 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 an 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 requests a third opinion.

CalOptima Health Policies and Procedures:

GG. 1538 Referral for Second 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 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. To request a second opinion for a CalOptima Health member, submit the request via the Provider Portal or fax the ARF to CalOptima Health's Utilization Management department.

3. Referrals for second opinions should be directed to a provider who is contracted with the member's health network. Referrals to noncontracting medical providers or facilities will be approved only when the requested services are not available within the contracting network.

4. Medical second 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 OneCare, and if it is medically necessary, OneCare or the member's OneCare health network will provide or arrange for services.

6. If OneCare or the member's 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.9015: Standard Integrated Appeals and MA.9004: Expedited Pre-Service Integrated Appeal
   c. Information about how to contact and file a complaint with the Department of Managed Health Care
7. 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 a third opinion.

CalOptima Health Policies and Procedures:

GG.1538 Referral for Second Opinion

MA.9015 Standard Integrated Appeals

MA.9004: Expedited Pre-Service Integrated 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 COD or CHCN 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 listing of the aid codes included in CalOptima Health and the aid codes for 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 their 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 to accurately identify the member.
   b. **Member's Date of Birth** — The member's date of birth is required 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, as well as the member's age and 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, substantiating the medical necessity is required. A diagnosis or test name is not adequate. To expedite and ensure your authorization request is processed, please ensure 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 and CalOptima Health Community Network Providers

This section applies to the following CalOptima Health programs:

Medi-Cal

F6: CALOPTIMA HEALTH DIRECT SERVICES REQUIRING AUTHORIZATION

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
- Nonemergency 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 noncontracted 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 and CalOptima Health Community Network 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 the patient's ability to attain, maintain or regain maximum function
- Result in loss of life, limb or other major bodily function

All referrals that do not meet urgent criteria may be downgraded to a routine referral request and will follow the 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 and CalOptima Health Community Network 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) and Level B (NF-B)

GG.1802: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from ICF/DD, ICF/DD-H, 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-Network 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. Prescribing and referred-to provider's full name, address and telephone number along with the 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
   e. Clinical indications necessitating the need for a wheelchair
   f. Pertinent medical history

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/for-providers/provider-common-forms

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), 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 an 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 the 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 FOR 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, do not exceed frequency limitations and 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: NONEMERGENCY MEDICAL TRANSPORTATION REQUESTS

Nonemergency medical transportation (NEMT) services are a Medi-Cal-covered benefit. If a CalOptima Health member is not able to ride in a taxi, by bus, passenger car or another form of public or private conveyance, and transportation is required for the purpose of obtaining medical care by a licensed provider, 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:

- Are not able to sit up and must ride lying down
- Are in a wheelchair and not able to move in and out of the chair into a seat, or are not able to move the chair without assistance
- Need 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). The PCS form must have the provider's typed or handwritten name and signature.
- 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 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 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 Nonemergency Medical Transportation Authorization Request, which includes the PCS. To obtain a copy of this form, please visit the Provider's section of the CalOptima Health website.

4. Please be sure to include the following on the Nonemergency 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 Nonemergency 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 exceeding 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 noncontracted 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 one-year 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 one-year.

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. The decision may be deferred, and the time limit extended up to 14 calendar days from original date of receipt of the request.

- 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 calendar days to obtain the documents from the nursing facility and make a decision.

- 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 submits a claim for payment, the applicable claims processing guidelines are determined by whether the member is enrolled in a health network or COD, and by the specific type of health network. COD and each CalOptima Health-contracted network maintain their own distinct claims processing function.

As a result, it is crucial for providers to verify a member's network affiliation before submitting a claim. **This affiliation determines both the destination for claim submission and the specific claims processing guidelines that apply.**

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.
- **COD/CHCN 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 Health Services – AHN (HMO) **Medi-Cal** **AltaMed Health Services (SRG)** **OneCare**	AltaMed Health Services P.O. Box 7280 Los Angeles, CA 90022-7280 **c/o Altura MSO, Inc.**	**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 **OneCare Claims:** CalOptima Health OneCare Claims P.O. Box 11065 Orange, CA 92856 (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 - c/o Rady Children's 3020 Children's Way Mail code 5144 San Diego, CA 92123	Rady's Children's Hospital San Diego Attn: CHOC/CPN Claims - c/o Rady Children's 3020 Children's Way Mail code 5144 San Diego, CA 92123
Family Choice Health Services (HMO) **Medi-Cal** **Family Choice Medical Group (SRG)** **OneCare**	Family Choice Medical Group c/o Altura P.O. Box 7280 Los Angeles, CA 90022-0980	**Medi-Cal:** Family Choice Health Network P.O. Box 7280 Los Angeles, CA 90022-0980 **OneCare:** 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 Claims Department P.O. Box 11065 Orange, CA 92856 **OneCare:** CalOptima Health OneCare Claims P.O. Box 11065 Orange, CA 92856 (See **Section H4** of this manual for details)

Health Network	Professional Claims	Facility Claims
Optum (HMO) **Medi-Cal, OneCare**	Optum Claims 9 Technology Drive Irvine, CA 92618	Optum Claims 9Technology Drive Irvine, CA 92618
Prospect Medical Group (HMO) **Medi-Cal, OneCare**	Prospect Medical P.O. Box 11466 Santa Ana, CA 92711-1466	Prospect Medical P.O. Box 11466 Santa Ana, CA 92711-1466
Providence (SRG) **Medi-Cal**	Providence PO Box 10 Anaheim, CA 92815-0010	CalOptima Health P.O. Box 11065 Orange, CA 92856
United Care Medical Group (SRG) **Medi-Cal, OneCare**	P.O. Box 11466 Santa Ana, CA 92711	**Electronic Claims:** Emdeon or Office Ally (See **Section H3** of this manual for details) **Hard Copy Claims (Medi-Cal):** CalOptima Health Direct Claims P.O. Box 11065 Orange, CA 92856 **OneCare:** CalOptima Health OneCare Claims: P.O. Box 11065 Orange, CA 92856 (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 5 p.m.

This section applies to the following CalOptima Health programs:

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

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:

- COD fee-for-service claims (professional and facility)
- CalOptima Health 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.** PHC and 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.

- 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.
- Claims Filing Time Frames — A provider will submit a claim for covered services provided to a COD-A member, CHCN member or a member enrolled in an SRG within 365 calendar days after the month of the date of service. Refer to policy FF.2001, Section E Claim Filing Deadlines

ONECARE

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

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 CMS guidelines for the timely filing of claims. Providers should file claims within the applicable time frames.

- Claims not submitted within the appropriate time frame will be denied.

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 noncontracted 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.

- 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 DHCS.

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 5 p.m.

CalOptima Health Policies and Procedures:

FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible

MA. 3101: Claims Processing for OneCare and PACE

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

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. 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 COD claims, as well as SRG facility claims and some SRG ancillary claims. The SRGs are responsible for payment of professional claims for their Medi-Cal members. HMO and 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: Claims Submission.**

The OneCare Claims department is responsible for processing claims for facility services rendered to OneCare members. OneCare health networks are responsible for the payment of professional claims for OneCare members. For more information on professional service claims, please see **Section H1:Claims Submission**. 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 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 the vendor listed below:

  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** —. 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).

- Claim Resubmission
  - CMS-1500: Refer to H4: Hard Copy Claims Submission: COD, Shared Risk, OneCare (HMO D-SNP)
  - UB-04: Refer to H4: Hard Copy Claims Submission: COD, Shared Risk, OneCare (HMO D-SNP)

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 www.caloptima.org/en/ForProviders/ProviderPortal. For more information on verifying a member's eligibility, see **Section E1: Verifying Member Eligibility.**

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8600,** 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

H4: HARD COPY CLAIMS SUBMISSION: CALOPTIMA HEALTH DIRECT, SHARED RISK, ONECARE

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 CMS 1500 and UB04 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**

Note: The CalOptima Health Claims department is responsible for processing COD claims, as well as SRG facility claims and some SRG ancillary claims. The SRGs are responsible for payment of professional claims for their Medi-Cal members. HMO and 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 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 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 or 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 nonglare 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 in a timely manner (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 COD or Shared-Risk Medi-Cal members, submit claims to CalOptima Health using the address below:

Original Claims:

Medi-Cal Program
CalOptima Health Claims Department
P.O. Box 11037
Orange, CA 92856

OneCare and PACE Program:
CalOptima Health Claims Department
P.O. BOX 11065
Orange, CA 92856

Corrected Claims:
ImageNet: CalOptima Health
P.O. BOX 11037
Orange, CA 92856

CLAIM RESUBMISSION

CMS-1500 and UB-04 forms must include the following:

- A clear indication as to what information has been changed.
- All procedures performed on a single date of service filed on one claim, even when submitting corrected claims with changed (i.e., added or deleted) codes or differing units.
- The original claim number assigned to your provider payment register/remittance advice.
- The Document Control Number (DCN) of the original claim reference number
- "Corrected Claim" clearly indicated with the applicable frequency code
    - Frequency code 7 indicates a replacement or corrected claim

Note: A corrected claim submitted to adjust a claim should not include an Appeal and Claims Dispute Form, letter of appeal, Appeal Request Form or medical records. Only the corrected claim should be submitted.

CHECKING THE STATUS OF A CLAIM ONLINE

Providers can view claims status and/or check status on the CalOptima Health Provider Portal 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 5 p.m.

CalOptima Health Policies and Procedures:

FF. 2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible

HH.2015: Health Networks Claims Processing

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 occurs when a member is eligible for both Medicare and Medi-Cal. Medicare pays its portion of the claim first, and the remaining deductible or coinsurance may be billed to Medi-Cal for most services. Medi-Cal's reimbursement is limited when combined with the Medicare payment and should not exceed Medi-Cal's maximum allowed for similar services. Any claim sent to COD for a Medicare deductible or coinsurance is considered a crossover claim.

Note: Claims for **Medi-Cal-covered services** provided to Medi-Medi members should be filed directly with COD according to the CalOptima Health Direct claims submission guidelines. For more information on claims billing guidelines, see **Sections H3 and H4** of this manual.

Guidelines for hard copy claims submitted to COD require complete CMS 1500 or UB04 forms with an 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	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 5 p.m.

This section applies to the following CalOptima Health programs:

Medi-Cal

H6: CLAIMS REJECTION NOTICE — CALOPTIMA HEALTH DIRECT

A returned claim notification letter indicates that CalOptima Health has recently received your claim for services rendered to a CalOptima Health member and the corrections required for processing your claim. The Reject Code Legend indicates the reason the claim was rejected on your CMS 1500 or UB04. A Claims Rejection Notice is accompanied by your claims. 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 CLAIMS REJECTION NOTICE

1. Upon receipt of a Claims Rejection Notice, carefully review the listed deficiencies, update the claim form with the appropriate corrections, and submit the original hard copy to:

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

2. Do not use the Provider Dispute Resolution (PDR) process.
   a. This claim will be considered a first-time submitted claim.

3. If you have not made the corrections for each claim, they will again be returned to your office.
   a. Do not attach the returned claims notification letter to your claims once corrected.

CalOptima Health Claims Rejection Notice

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 will 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 Provider Portal located on CalOptima Health's website. • 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 or UB-04. **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 5 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

State law requires CalOptima Health to be the payer of last resort when Other Health Coverage (OHC) is identified. Providers must coordinate benefits for covered services with other programs or entitlements, recognizing OHC as primary coverage prior to submitting a claim to CalOptima Health.

Providers enrolled in Medi-Cal Fee-for-Service (FFS) or as a Medicare provider do not need to be contracted with CalOptima Health to see and bill for routine services for a patient who is dual-eligible or has OHC and is enrolled in CalOptima Health. Providers who are enrolled in Medi-Cal FFS but do not contract with CalOptima Health 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.

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 OHC:
    a. CalOptima Health managed care*
    b. Automobile insurance
    c. Life insurance

***Note:** CalOptima Health managed care is not OHC. 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-contracted providers to notify DHCS if they believe a recipient may be entitled to OHC.

    a. All providers may use the DHCS OHC Removal or Addition Form to assist Medi-Cal members who need to update or remove their OHC from the state's system, available on the DHCS website.

    b. Providers should fill out and submit the applicable form with the member's consent (in-person or telephonic acceptable), or providers may direct members to fill out the DHCS OHC Removal or Addition Form on their own, if desired.

    c. Members and/or providers may also call the FFS Medi-Cal Telephone Service Center, 8 a.m. to 5 p.m., Monday through Friday, except holidays, at the toll-free number 1-800-541-5555, to remove the OHC.

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.

a. 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.
b. 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.
c. CalOptima Health is not liable for OHC-covered services if the recipient elects to seek treatment from a provider not authorized by the OHC.

3. **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.

    a. 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.

4. **When to bill OHC —** When requesting eligibility verification for a recipient with OHC, the CalOptima Health eligibility verification system returns a message stating the recipient's scope of coverage.

    a. If a recipient's OHC code is found on the Medi-Cal Eligibility Record and the service rendered falls within the recipient's scope of coverage, the provider must refer the recipient to the OHC or bill the OHC indicated on the eligibility verification message before billing CalOptima Health.

    b. The updated list of carrier codes is refreshed monthly and can be accessed through the Medi-Cal Automated Eligibility Verification System (AEVS) via telephone by calling **1-800-456-2387** or through the secure Medi-Cal Provider Portal.

CALHHS AUTOMATED ELIGIBILITY VERIFICATION SYSTEMS (AEVS)

On a monthly basis, DHCS provides the most updated list of active carrier codes and associated carrier information. To view the list of carrier codes, please visit the DHCS website: data.chhs.ca.gov/dataset/aevs-carrier-codes-for-other-health-coverage

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

COV Code	Service Category	Bill On (Claim Type)
I	Hospital inpatient	UB-04 Claim Form
O	Hospital outpatient	UB-04 Claim Form
M	Medical and allied services	CMS-1500 Claim Form
V	Vision care services	Payment Request for Vision Care and Appliances (45-1)
D	Dental services	Not applicable to EDS claims
R	Medicare Part D	As appropriate
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 CalOptima Health eligibility verification system will return the message "COMPREHENSIVE." 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 OHC insurance carriers, or the carrier codes if AEVS is accessed.

5. **Billing CalOptima Health after OHC —** 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 (EOB) indicating that the service is not covered by the 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 payment in full.
    e. An 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 OHC payment.

6. **OHC EOB or Denial Letter —** 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.
    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 noncovered benefits from the carrier is also acceptable if it matches both the insurance's and recipient's name and address and clearly states the benefits are 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.

7. **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 FFS
   b. Recipients who have CalOptima Health and Medicare HMO coverage must seek medical treatment through their Medicare HMO.
   c. 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.
   d. CalOptima Health claims for recipients with Medicare HMO coverage are not Medicare/CalOptima Health crossover claims.
      i. Therefore, to bill CalOptima Health for services not included in the Medicare HMO plan, submit a CalOptima Health claim accompanied by an 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.
   e. Most claims for Medicare/COD recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits.

   COD recipients are considered Medicare-eligible if they are 65 years of age or older, blind or disabled, or if the COD 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 claims, please see **Section H5: Submitting Crossover Claims**.

BILLING FOR MEDICARE NONCOVERED, EXHAUSTED OR DENIED SERVICES, OR MEDICARE NONELIGIBLE 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/UB-04 Submission and Timeliness Guidelines.

1. **Medicare noncovered services**

CalOptima Health maintains a list of Medicare noncovered codes that may be billed to COD claims for Medicare/COD recipients. Do not send these claims to the CalOptima Health Crossover Unit.

All services or supplies on a straight COD claim must be included in the Medicare noncovered services charts for direct billing.

a. If a service or supply is not included in the chart, submit the corresponding Explanation of Medicare Benefits (EOMB) showing the services or supplies that are not allowed by Medicare when billing COD.

2. Medicare exhausted services

a. After Medicare benefits have been exhausted, claims must be billed directly to COD on a CMS 1500, including a copy of the EOMB, showing the benefits that are exhausted.

b. Physical therapy and occupational therapy for COD patients with Medicare coverage must be billed to the appropriate Medicare carrier or intermediary.
   i. After Medicare benefits for physical and occupational therapy have been exhausted, providers may bill CalOptima Health directly and must include a copy of the EOMB showing the benefits are exhausted.

3. Medicare denied services

Medicare denied services should be billed as straight COD 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 EOMB indicating the denial.
e. If the Medicare denial description is not printed on the front of the EOMB, include a copy of the description from the back of the EOMB or the Medicare manual.
f. Attach a copy of any OHC 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 OHC on the CalOptima Health website at www.caloptima.org.
g. Do not send these claims to the Crossover Unit.

4. Services denied when included in surgical fee or for separately payable

COD does not pay for an office visit when Medicare has denied payment because the visit was included in the surgical fee.

a. 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.
b. COD does not pay for services denied by Medicare because the procedure is a component part of a group of services.
c. COD 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 NONCOVERED, EXHAUSTED OR DENIED SERVICES

The following billing tips will help prevent rejections, delays, incorrect payments and/or denials of claims for Medicare noncovered, exhausted or denied services:

1. A single claim form cannot be used when billing for the combination of Medicare-approved/covered services and Medicare noncovered, 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 noncovered, exhausted or denied services must be billed to COD. Use the CMS 1500 and attach a copy of the EOMB for the exhausted or denied services.

4. If a Medicare denial description is not printed on the front of an EOMB that shows a Medicare denied service, the provider must copy the Medicare denial descriptions from the back of the original EOMB or from the Medicare manual. The provider must submit it to COD along with the bill for the Medicare-denied services. This applies to any services denied by Medicare for any reason.

5. When billing Medicare noncovered, 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 COD.

BILLING TIPS FOR MEMBERS WITH MEDICARE AND OTHER HEALTH COVERAGE AS PRIMARY INSURANCE

When a recipient has both Medicare FFS 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 COD. Attach the EOMB/Medicare Remittance Notice and the OHC 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 5 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

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	Definite Duplicate Claim	Claim received for the same member, same services and same date of service. Be sure to check the 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 5 p.m.
X04	Procedure Requires Appropriate Modifier	Claims must be billed in accordance with applicable Medi-Cal/Medicare billing guidelines. Please review CMS and DHCS provider manuals to ensure services are billed correctly.
726	Bill Medicare, Send EOMB and Claim to HP	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 COD. If the service was paid by Medicare, send the EOMB and claim for crossover processing.
728	Proof of payment/denial required (OHC/Medicare Senior Plan)	Member has OHC. Proof of payment or denial from the OHC 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 5 p.m.
736	Bill According to MediCal/Medicare Guidance	Claims must be billed in accordance with applicable Medi-Cal/Medicare billing guidelines. Please review CMS and DHCS provider manuals to ensure services are billed correctly.

EOC	DESCRIPTIONS	BILLING TIPS
X01	a covered benefit	

COMMON CLAIMS DENIAL REASONS — ONECARE

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 the OneCare Claims department to deny a claim.

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.
Each health network will have its own EOC	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 5 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.

        i. 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.

        ii. 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.

b. 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.

c. 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**.

d. 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.

e. 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).

f. 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.

g. 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 is the only record of CalOptima Health Direct claims adjudication you will receive. Please keep the 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 5 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 UB-04 claim form with a National Drug Code (NDC), per DHCS.

The NDC is a number that identifies a specific drug, and is found on the drug container (vial, bottle or tube). The NDC submitted on the claim must be the NDC number on the package or container from which the medication was administered. Providers should not bill for one manufacturer's product and administer another. It is considered fraudulent billing to enter an NDC on the claim for a drug other than the one administered.

For claim form completion instructions, refer to the sections below of the Medi-Cal Provider Manual.

- Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions
- Physician-Administered Drugs – NDC: UB-04 Billing Instructions
- CMS-1500 Completion
- UB-04 Completion: Outpatient Services
- UB-04 Completion: Inpatient Services

BILLING TIPS FOR SUBMITTING NDC NUMBERS

What is an NDC Number?

1. 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.
2. 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.**
3. 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

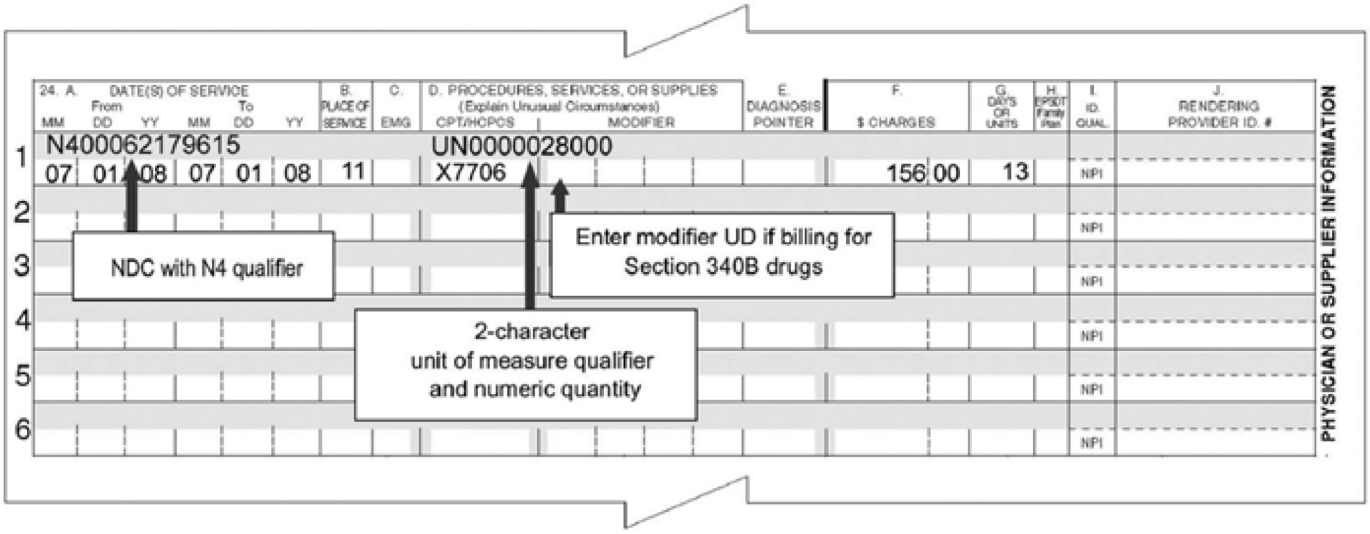
In the shaded area of Box 24A, enter the product ID qualifier N4 and NDC followed by the 11-digit NDC. Omit spaces and hyphens.

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
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 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. to5 p.m. .

This section applies to the following CalOptima Health programs:

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

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. Providers who want to dispute a health network claim should contact the health network directly. For more information on how to file with CalOptima Health's Grievance and Appeals department, see **Section R1: Provider Complaint Process.**

PDR DETERMINATION RESULTING IN ADDITIONAL PAYMENT

If CalOptima Health determines that additional payment is owed based on information that was originally provided or available at the time the claim was first submitted, or due to a processing error, CalOptima Health will automatically include the appropriate interest when payment is not issued within the required regulatory time frames.

CALOPTIMA HEALTH ONECARE CLAIMS

OneCare offers the PDR process for contracted providers to resolve claim issues. **Noncontracted providers should follow the protocol outlined in Section R1: Provider Complaint Process**. Furthermore, this guidance only applies to facility claims, since OneCare is 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. 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

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

HH.1101: CalOptima Health Provider Complaint

MA.9009: Non-Contracted Provider Complaint Process

For more complex claims questions, contact the Claims Resolution Unit 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

H12: MEMBER BILLING RESTRICTIONS

MEDI-CAL

Federal and state law prohibits health care providers from charging and/or collecting payment from members, or other persons on behalf of the member, for covered services. Additionally, under no circumstances can a provider deny services to a CalOptima Health member for nonpayment of a missed appointment or lack of payment for copayments and deductibles. 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.

BILLING MEMBERS FOR COVERED SERVICES IS PROHIBITED

1. 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.

2. Noncontracted providers may not bill or collect payment from a CalOptima Health member or their representative for authorized, urgent or emergent covered services.

3. Providers may not bill a member for a claim denied due to lack of authorization or untimely filing.

4. Providers should refrain from asking CalOptima Health members to inquire about the status of a claim or involve the member in any efforts to obtain payment from CalOptima Health.

ONECARE

RESTRICTIONS ON BILLING MEMBERS FOR COVERED SERVICES

1. Providers contracted with OneCare health networks cannot bill OneCare members for covered services, except for applicable coinsurance or copayment amounts. Furthermore, providers cannot sue a member to collect sums owed by OneCare or its contracted health network.

2. The prohibition on billing of the member includes, but is not limited to:

    a. Covered services (including both Medicare- and Medi-Cal-covered services)

    b. Covered services provided during a period of retroactive eligibility

    c. Covered services once the member meets their share of cost requirement

    d. Copayments, coinsurance, deductible or other cost-sharing required under a member's OHC

    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, 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:

1. The member agrees to the fees in writing prior to the actual delivery of the noncovered services.
2. A copy of the written agreement is provided to the member and placed in the member's 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 5 p.m.

CalOptima Health Policies and Procedures:

AA.1220: Member Billing

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 **Consent for Sterilization DHCS 8649** 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

- **Starting on October 16, 2025, the Department of Health Care Services (DHCS) will replace the current Consent for Sterilization PM 330 Form to the new Consent for Sterilization DHCS 8649 Form.**
    a. DHCS will continue to accept the PM 330 form through August 31, 2026, to ensure a smooth transition and to avoid claim denials.
- Starting on **September 1, 2026**, the DHCS 8649 form will be the **only form accepted** by Medi-Cal for sterilization procedures.
    a. Failure to use DHCS 8649 after September 1, 2026, will result in the claim being denied.
- Claims submitted with a computer-generated form or any other pre-printed version of the Consent for Sterilization form 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 (**Consent for Sterilization DHCS 8649)**
- 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 Consent for Sterilization Form 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 5 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 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 (HMO D-SNP), a Medicare Medi-Cal Plan

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. Have an ICD-10 diagnosis code for three or more of the following diseases:
    - Alzheimer's disease
    - Bone disease-arthritis, including osteoporosis, osteoarthritis, and rheumatoid arthritis
    - Congestive heart failure
    - Diabetes
    - Dyslipidemia
    - End-stage renal disease
    - Human immunodeficiency virus or acquired immunodeficiency syndrome
    - Hypertension
    - Mental health, including depression, schizophrenia, bipolar disorder, and chronic/ disabling mental health conditions
    - Respiratory disease including asthma, chronic obstructive pulmonary disease (COPD), and chronic lung disorders
2. Are receiving eight or more different maintenance Part D 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 are required to provide 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 (HMO D-SNP), a Medicare Medi-Cal Plan

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 OneCare Pharmacy Resources under the Providers section of the CalOptima Health website at www.caloptima.org/.

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 members with complex health needs who will benefit from care coordination services. 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 case manager 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, their 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. **COD and 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 an 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, they can 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 AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN)

Children and Youth with Special Health Care Needs (CYSHCN) means Children and Youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that required by Children and Youth generally. The identification, assessment, treatment, and coordination of care for CYSHCN must comply with the requirements of 42 CFR sections 438.208(b)(3), 438.208(b)(4), and 438.208(c)(2) – (4).

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 and youth with special health care needs
3. Case management services with other entities that also serve these children and youth
4. Monitoring and improving the quality and appropriateness of care to children and youth with special health care needs

Who are children and youth with special health care needs?

Children and youth 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 and youth with special health care need case management

The purpose of children and youth 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 and youth 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 and youth 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 or youth 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**).

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**).

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:

OneCare

J5: 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 California Integrated Care Management (CICM). 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. CICM members: Members who meet the eligibility criteria for the Medi-Cal ECM Population of Focus or are eligible for palliative care.
    - Adults experiencing homelessness
    - Adults at risk for avoidable hospital or ED admission
    - Adults with serious mental illness and/or SUD
    - Adults transitioning from incarceration
    - Individuals living in the community and at risk for long-term care (LTC) institutionalization
    - Adults nursing facility residents transitioning to the community
    - Adults who are pregnant or postpartum and subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality
    - Individuals with serious illness who are eligible for palliative care as defined by Medi-Cal palliative care general and disease-specific eligibility criteria

2. Adults with documented dementia needs, defined as members living with dementia who also meet one of the following criteria:
    - Has two or more coexisting conditions
    - Has moderate to severe behavioral issues
    - Is a high utilizer
    - Lives alone
    - Lacks adequate caregiver support
    - Has moderate to severe functional impairment

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

J6: 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:

- 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
- Health status and health disparities, such as health status, where OneCare members live, living conditions, social and environmental context, and COVID-19 vulnerability
- Demographics such as age, gender, race/ethnicity, language and health disparities
- Unique characteristics of the OneCare population

Description of OneCare Population: Most Vulnerable Members

OneCare has identified the following members as the most vulnerable members:

- California Integrated Care Management (CICM) members:
    a. Adults experiencing homelessness
    b. Adults at risk for avoidable hospital or ED admission
    c. Adults with serious mental illness and/or SUD
    d. Adults transitioning from incarceration
    e. Individuals living in the community and at risk for long-term care (LTC) institutionalization
    f. Adults nursing facility residents transitioning to the community
    g. Adults who are pregnant or postpartum and subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality
    h. Individuals with serious illness who are eligible for palliative care
- Adults with documented dementia needs

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 (ICT) or CalOptima Health's case management team or designee

- **Individualized Care Plan (ICP)** — A plan of care for the OneCare member based on information from the HRA
- **ICT** — The ICT includes the member's PCP, case manager and others, as appropriate. Each OneCare member has a care team to ensure care coordination occurs in a structured collaborative process. The team is involved in the creation and updates of the ICP. They may have formal meetings as needed to discuss the member's care, review the ICP and ensure care coordination occurs as appropriate
- **Care Transition Protocols** — Guidelines on how to manage the OneCare member across the care continuum

Care Coordination: Staff Structure and Roles

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

- Administrative staff
- 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 (within 90 days of enrollment) and 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, virtual, telephonic or paper-based.
- HRA identifies care needs 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:

- CalOptima Health ensures that all OneCare members have an 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 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 member's 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
- Members receiving palliative care will include a palliative care team member in their ICT.

The ICT composition is determined based on the member's medical condition and their responses to the HRA.

- All members receive informal ICTs, with all participants contributing to the development and coordinating 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 a behavioral health specialist, clinical pharmacist, dietician, LTSS coordinator, utilization management nurse, facility discharge planner, palliative care team, dementia care specialist, therapist and community-based organization may be included in the ICT based on the member's specific needs.

Care Coordination: Care Transition Protocols

The 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. The OneCare Transition Program protocols are provided to all members to address transition needs and include assignment of a single point of contact to support a member through a transition event.

The OneCare Transition Program includes, but is not limited to, the following programmatic objectives for planned and unplanned transitions:

- Early identification of risk
- Utilization management support, case management interventions and self-management coaching of members through transition events
- Communication with the ICT, practitioners and providers, and the member
- Reduction of unnecessary emergency department use and unplanned transitions
- Analyzing, tracking and trending utilization and assessment data for process improvement opportunities

Member receives outreach within two business days for screening or assessment and a communication plan for ICP follow-up. Elements of the ICP are also shared between care setting providers within two business days of notification that a transition has occurred. The utilization management inpatient review nurse, care coordinator or case manager is responsible for communicating with the member or their designee and health care setting teams regarding changes to the member's health status and ICP.

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. Ancillary services
    l. Community-based palliative care providers

- Facilities such as:
    a. Acute facilities, including behavioral health and rehabilitation facilities
    b. Dialysis centers
    c. Specialty outpatient clinics
    d. Residential care facilities
    e. Radiology and imagining facilities
    f. Laboratory facilities
- Use of evidence-based clinical guidelines and care transition protocols to formalize oversight of provider network adherence to nationally recognized care standards
- OneCare MOC 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 ensure they use nationally recognized clinical practice guidelines
- Ensuring, through a formal credentialing review, that network providers are licensed and competent
- Having a broad network of specialists, including palliative care providers, pain management providers, 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:

- Quality Improvement Committee
- 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 to measure 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 the 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 the 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

J7: CONTINUITY OF CARE

OVERVIEW

CalOptima Health is required to provide continuity of care as set forth in a Memorandum of Understanding (MOU) with 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 their 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 or the member's health network must offer continuity of care with an out-of-network provider to all Medi-Cal and 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 or the member’s health network based on the current Medicare or Medi-Cal fee schedule, as applicable.
- CalOptima Health or the member’s health network 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 or the member’s health network 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 or the member's health network 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 it is 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 or the member's health network must provide continuity of care for services, but are not obligated to use out-of-network providers who 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 noncontracting provider in effect for the member immediately prior to the date of enrollment. This applies whether the drug is covered by CalOptima Health, until the prescribed therapy is no longer prescribed by the contracted physician, as outlined in CalOptima Health policy MA. 6110 Transition Process.

Additional requirements pertaining to continuity of care require CalOptima Health or the member's health network, at the request of the member, their authorized representatives or their treating providers, to provide for the completion of covered services by a terminated or nonparticipating CalOptima Health provider. CalOptima Health or the member's health network 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 or the member's health network must allow for the completion of these services for certain time frames, which are specific to each condition.

CalOptima Health Policies and Procedures:

GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services

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

MA.6021a: Continuity of Care for New Members

MA. 6110: Transition Process

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. A physical injury which is inflicted by other than accidental means on a child by another person.
2. Sexual Abuse, including both sexual assault and sexual exploitation.
3. Willful cruelty or unjustifiable punishment of a child.
4. Cruel or inhuman corporal punishment or injury.
5. Neglect, including both severe and general neglect.

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 while school is in session. 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. Family Therapy Benefit

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 California Department of Public Health, 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 (TB tests, 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. Newly arriving refugees
5. Newly arriving immigrants required by the CDC Division of Global Migration and Quarantine to be evaluated for TB
6. Persons with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)
7. Clients of shelters
8. Clients of residential detoxification centers, and drug and alcohol treatment centers

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:

   OC 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 Centers. 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, PACE

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 CHCN 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 if there is a state-level enrollment pathway through DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.
- 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, Medicare (OneCare) and PACE programs.
- The provider must 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 contracting with CalOptima Health's Medi-Cal, Medicare or PACE programs can obtain information from the Providers section of CalOptima Health's website**,** www.caloptima.org/en/for-providers.

- **Contract With a Health Network**
  Providers interested in contracting with CalOptima Health's health networks should contact the health network directly. For contact information, see **Section B1: CalOptima Health Department and Program Contact Information**.

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 nonphysician 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, they 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**.

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

Advanced Practice Professionals (APPs) — CalOptima Health and its health networks credential APPs. APPs 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 Provider Credentialing Standards — CalOptima Health requires all providers to meet CalOptima Health's Minimum Provider Credentialing Standards, in accordance with CalOptima Health policy GG.1643, prior to completing a credentialing application for both CHCN 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:

- 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, preclusions, suspensions or ineligibility to participate in any state or federal health care program
- Enrollment 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 an 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 CHCN must first contact CalOptima Health's Provider Resource line at **714-246-8600**. CalOptima Health Provider Relations will notify CalOptima Health's Credentialing department of the provider's desire to participate in CHCN. 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 will, at a 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.
- 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 Provider Credentialing 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. Delegation of services agreement for physician assistants (PAs) signed by the supervising physician. This physician must be presently credentialed with CalOptima Health and enrolled with Medi-Cal.
    8. Procedures and protocols for NPs signed by the supervising physician. This physician must be presently credentialed with CalOptima Health and enrolled with Medi-Cal.

If the provider intends to contract as a PCP, 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 120 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 the initial approved credentialing date) and, if the practitioner has contracted with CHCN, the provider will be contacted to confirm contact information of both the practitioner and their credentialing contact.
- If the provider has not yet completed the CAQH application, they will need to do so at recredentialing. Once the provider has completed the CAQH application, they must authorize CalOptima Health to access it. CAQH will notify the provider to update and attest to the contents of the CAQH application on a quarterly basis.
- CalOptima Health staff will contact the provider about scheduling the full-scope FSR. For more information, see **Section M2: Facility Site Review, Medical Record Review and Physical Accessibility Review Survey**.

CalOptima Health will render a decision within 120 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**.

CalOptima Health Policies and Procedures:

GG.1650: Credentialing and Recredentialing of Practitioners

GG.1643: Minimum Provider Credentialing 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

DHCS requires CalOptima Health to have adequate facilities and service site locations available to meet the contractual requirements for delivering primary care to CalOptima Health members.

The site review process is part of CalOptima Health's Credentialing and Quality Improvement programs, which focus on the capacity of each PCP site to ensure and support the safe and effective provision of appropriate clinical services.

To ensure compliance, CalOptima Health is required to perform initial and subsequent PCP site reviews during the initial provider credentialing process and at least every three years as part of the recredentialing process. The reviews consist of an FSR, an MRR and a PARS, utilizing the DHCS FSR and MRR tools and standards, as well as the PARS tools.

FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices. The FSR confirms the PCP operates in compliance with all applicable local, state, and federal laws and regulations.

MRRs are conducted to review medical records for format, adherence to legal protocols, and documentation of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the member received care. Incomplete records or a lack of documentation imply the PCP did not provide quality, timely or appropriate medical care.

PARS is a physical evaluation of service sites to ensure that facilities meet the needs of Medi-Cal members, particularly seniors and individuals with disabilities. PARS is used to identify potential accessibility barriers to provider sites and improve service delivery to CalOptima Health members. The results of the PARS are informational and do not require corrective action. The survey focuses on six key areas:

- Parking
- Exterior building
- Interior building
- Restroom
- Exam room
- Exam table/scale

.

KEY POINTS REGARDING THE FSR AND MRR

- FSRs include a review of available documented evidence, demonstration of the criteria, on-site inspection and verbal interviews with site personnel. Components of the FSR tool include:
    - Access/safety
    - Personnel
    - Office management
    - Clinical services
    - Preventive services
    - Infection control

- The FSR tool is composed of both critical and noncritical elements. Critical elements have the largest potential for adverse effects on patient health and safety and are assigned a weighted score of two points. Noncritical review elements have a scored weight of one point. Compliance levels include:
    - Exempted Pass: 90% or above without deficiencies in critical elements, pharmaceutical or infection control. No corrective action plan (CAP) required.
    - Conditional Pass: 80-89%, or 90% and above with deficiencies in either critical elements, pharmaceutical or infection control. CAP required.
    - Fail: 79% and below. CAP required.
- An initial site review consists of an FSR and MRR. The FSR is conducted first to ensure the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. PCPs will not be added to the CalOptima Health provider network or have members assigned until the PCP sites receive a passing FSR score and submit all CAPs.
- The MRR is conducted to ensure compliance with regulatory standards and assess the quality management of health conditions and oversight of preventive services.
- The MRR is an evaluation of a member's medical record according to:
    - Format
    - Documentation
    - Continuity or coordination of care
    - Pediatric preventive services (as appropriate)
    - Adult preventive services (as appropriate)
    - Obstetric preventive care (when applicable)
- Medical records will be randomly selected using a methodology decided upon by the certified reviewer. Documented evidence found in the hard copy medical records and/or electronic medical records, including immunization registries, is used for reviewing criteria determinations. The review score is based on a review standard of 10 records per individual PCP. Compliance levels are:
    - Exempted Pass: 90% or above
    - Conditional Pass: 80-89%
    - Fail: 79% and below
    - The minimum passing score is 80%. A CAP is required for a total MRR score below 90%. Any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.
- A CAP is required for all cited deficiencies for PCP sites that have an FSR and/or MRR conditional pass or non-passing score. CalOptima Health follows DHCS-established timelines for CAP notification and completion.
- If a PCP site receives a failing score on an FSR or MRR, CalOptima Health will notify the site of the score, all cited deficiencies and all CAP requirements. No new members can be assigned until CalOptima Health verifies that the deficiencies have been corrected and the CAPs are closed.
- Additional training, technical assistance and subsequent annual FSRs and MRRs are required for all sites with failed FSR and/or MRR scores.
- If a PCP site fails the FSR or MRR on the third consecutive attempt, the PCP site will not have an opportunity to complete a CAP and must be removed from the CalOptima Health provider network. The PCP can reapply to join the CalOptima Health provider network after a three-year period.

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 in accordance with the recommendations of 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 seniors and people with disabilities (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:** www.caloptima.org/en/for-providers/provider-resources/manuals-policies-and-guides**)**
- 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's chart.
- Members with unsuccessful IHA completions require a minimum of three documented outreach attempts. Examples of outreach attempts 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 includes 87 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 a health plan's performance to other plans and 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 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 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 Whole Person Care and Whole-Child Model programs.

Data Collection Methods

HEDIS measures are specified for one or more of four data collection methods:

- **Administrative Method:** Members who are found through administrative data to have received the service required for the numerator.
- **Hybrid Method:** Medical records are reviewed to capture services not found in the administrative claim data to create a more accurate representation of the care provided to the member. This method applies to only a few selected measures.
- **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):** Standardized way to report measures using electronic clinical data from various sources, such as electronic health records (EHR), health information exchanges (HIEs) registries and case management systems, in addition to traditional claims data.

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 medical records to determine whether the member received the

required service for the measure. 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 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:

- Providers 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).
- Providers 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 DHCS, CMS and NCQA for compliance, providers 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, 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 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, providers 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 PHI to 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, and HEDIS falls under health care operations. In addition, CalOptima Health members sign a medical records release form at the time of enrollment, so it is not necessary for a provider to obtain a release.

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, a list of members' 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 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 that 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 2025 hybrid measures is posted on the CalOptima Health website: HEDIS Documentation Requirements for Providers

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 the Department of Health Care Services (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. Interpreter services are to be made readily available at the time of appointment and without causing a delay in scheduling. CalOptima Health is also required to ensure its subcontractors, downstream subcontractors and network providers participate in the Timely Access Survey administered by DHCS.

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 (IHA)	Within 120 calendar days of enrollment into CalOptima Health, or within periodicity timelines established by the American Academy of Pediatrics (AAP)/Bright Futures for members less than 18 months of age
Non-Urgent Appointments for Primary Care	Within 10 business days of request
Non-Urgent Appointments With Specialist Physicians	Within 15 business days of request

Type of Care	Standard
Non-Urgent Follow-up Appointments for Physician Behavioral Health Care Providers (Psychiatrist)	Within 30 calendar days of request
Non-Urgent Appointments for Ancillary Services	Within 15 business days of request
Non-Urgent Appointment With a Non-Physician Mental Health Provider	Within 10 business days of request
Non-Urgent Follow-up Appointment With a Non-Physician Mental Health Provider	Within 10 business days of prior appointment

Telephone Access Standards:

Description	Standard
Telephone Nurse Triage or Screening Services	Telephone triage or screening will be available 24/7. Telephone nurse 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 on: • The length of wait time for a return call from the provider • How the caller may obtain urgent or emergency care
After-Hours Access	A primary care provider (PCP) or designee will be available 24/7 to respond to after-hours calls from members or a hospital emergency room practitioner

Cultural and Linguistic Standards:

Description	Standard
Oral Interpretation	Oral interpretation, including but not limited to American 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

Description	Standard
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
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
Moral Objection	In the event a provider has a religious, moral or ethical objection to performing or otherwise supporting the provision of covered services, CalOptima Health or its contracted health network must in a timely manner arrange for, coordinate and ensure member receives 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 the 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

Description	Standard
Minor Consent Services	Covered services of a sensitive nature which minors do not need parental consent to access
Family Planning Services	Members will have access to family planning and sexually transmitted disease services from a provider of the member's choice without referral or prior authorization, either in or out-of-network

CalOptima Health Policies and Procedures:

DD.2002: Cultural and Linguistic Services

GG.1118: Family Planning Services, Out-of-Network

GG.1508: Authorization and Processing of Referrals

GG.1600: Access and Availability

This section applies to the following CalOptima Health programs:

OneCare

ACCESS STANDARDS

CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is required to adhere to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (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 providers and health networks are expected to comply with these appointments, telephone access, practitioner availability and linguistic service standards. Interpreter services are made available at the time of the appointment and without causing a delay to appointment scheduling. OneCare monitors its 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 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 Require Medical Attention	Within seven 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 American 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

Description	Standard
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 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 will 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

CalOptima Health Policies and Procedures:

DD.2002: Cultural and Linguistic Services

GG.1118: Family Planning Services, Out-of-Network

GG.1508: Authorization and Processing of Referrals

MA.7007: Access and Availability

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 part of this monitoring effort, CalOptima Health has a process in place for identifying and receiving reports of potential quality of care issues. CalOptima Health conducts case reviews, investigates potential quality of care issues and determines the severity of issues. Based on these investigations, CalOptima Health determines the appropriate follow-up action required for individual cases. We also aggregate data on potential quality of care issues 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, but is not limited to, the following:
    a. Delay in care or treatment or 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:

  Mail:
  CalOptima Health
  Attention: Quality Improvement Department
  505 City Parkway West
  Orange, CA 92868

  Email: qualityofcare@caloptima.org

  Fax: **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 Issue 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 response to the complaint. CalOptima Health will conduct a case review of the information received and evaluate the issue.

b. **CHCN and COD**— If the case involves a CHCN or COD member, CalOptima Health will request documents, which may include medical records and a response from the rendering provider. CalOptima Health will 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 Committee may request corrective action or recommend recredentialing 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

Customer Service provides the following services, which assist both members and providers:

1. **Call Center Services:** CalOptima Health and its health networks must ensure that, during normal business hours, calls made to the Customer Service line do not exceed a waiting time of 10 minutes for a member to speak with Customer Service staff who are knowledgeable and competent about their inquiry. The CalOptima Health Customer Service department call center handles incoming member and provider calls regarding eligibility, benefits, prior authorization status, coordination of care and other issues. We have staff available to assist in the following languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese, Arabic and Russian. 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 team 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:** CalOptima Health and health networks are required to demonstrate compliance with timely access standards and the availability of interpretation services to ensure interpreter services are made readily available at the time of appointments and without causing delay to appointment scheduling.

   CalOptima Health and its health networks are required to provide members with limited proficiency in English who are seeking or obtaining care with an interpreter or provider who speaks their primary language, 24/7. In addition, CalOptima Health and its health networks must meet requirements to provide linguistic services, including oral interpreters, American Sign Language interpreters, or bilingual providers and provider staff. CalOptima Health's Customer Service department 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 data on member selections and health network changes, as well as data on any PCP selections and changes that occur with a health network change.

HOW TO CONTACT CALOPTIMA HEALTH'S CUSTOMER SERVICE DEPARTMENT FOR ASSISTANCE

To reach CalOptima Health's Customer Service department with questions about CalOptima Health members, 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, Vietnamese, Farsi, Korean, Chinese, Arabic and Russian. 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

CalOptima Health and its health networks must ensure that during normal business hours, calls made to the Customer Service line do not exceed a waiting time of 10 minutes for a member to speak with Customer Service staff who are knowledgeable and competent about their inquiry. Members can call OneCare Customer Service 24/7 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
CalOptima Health and its health networks are required to provide members who have limited proficiency in English with an interpreter or provider who speaks the member's primary language when members are seeking or obtaining care, 24/7. In addition, CalOptima Health and its health networks must meet requirements to provide linguistic services, including oral interpreters, American Sign Language interpreters, or bilingual providers and provider staff. CalOptima Health's Cultural and Linguistic Services department 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 TEAM FOR SENIORS AND PERSONS WITH DISABILITIES

The Member Liaison team 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 guide CalOptima Health members through the health care system. They help members obtain proper care, receive timely referrals to services, and connect with health and community resources by providing direct intervention and/or education for self-advocacy. Except for in December, the Member Liaison team 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. Connecting members with their health care providers to schedule appointments.
2. Arranging for nonemergency 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 CONTACT THE MEMBER LIAISON TEAM

If you have a patient who falls under the aid code chart below, and you or your patient would like to obtain more information about the services offered by the Member Liaison team, 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
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 SELECTION

CalOptima Health is committed to ensuring that its health network-eligible members have ample opportunity to select a 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 eligible members who enroll in a health network.

Choice Upon Initial Enrollment Into CalOptima Health

1. New CalOptima Health members have the opportunity to select a PCP and a health network upon enrollment.

2. New members receive a welcome packet containing a Health Network Selection Form and a Health Network Selection Form Guide, which lists CalOptima Health's health networks.

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 their 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 their 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 and/or PCP, CalOptima Health will auto-assign the member to a health network and/or PCP based on a predetermined algorithm.

7. CalOptima Health members can also make health network and PCP selections by accessing the CalOptima Health Member Portal or requesting the change by calling the CalOptima Health Customer Service department at **888-587-8808**.

8. A health network-eligible member may change their 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, CalOptima Health will ask the member to choose another PCP.

2. Members may change their PCP through CalOptima Health every 30 days.

3. Members may request to change their PCP by contacting CalOptima Health.

Some CalOptima Health members are enrolled in COD 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 and CalOptima Health Community Network
DD.2006b: Member Primary Care Provider Selection/Assignment

This section applies to the following CalOptima Health programs:

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

N3: HEALTH NETWORK AND PRIMARY CARE PROVIDER SELECTION

OneCare is committed to ensuring that its members have ample opportunity to select a 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**
    a. During the enrollment process, new OneCare members complete an enrollment form on which they can make a PCP and health network selection.
    b. Members 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 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 OneCare members receive a Provider Directory Insert that explains the process of accessing or requesting a Provider Directory.
    b. Members may choose any of the doctors listed in the OneCare 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 accessing the CalOptima Health Member Portal or by requesting the change 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 those rights and responsibilities are respected and observed. CalOptima Health provides this information to members in the Member Handbook, 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:

1. To be treated with respect and dignity, and given due consideration to their right to privacy and the need to maintain confidentiality of their medical information, such as medical history, mental and physical condition or treatment, and reproductive or sexual health
2. To be provided with information about the health plan and its services, including covered services, providers, practitioners, and member rights and responsibilities
3. To get fully translated written member information in their preferred language, including all grievance and appeals notices
4. To make recommendations about CalOptima Health's member rights and responsibilities policy
5. To be able to choose a PCP within CalOptima Health's network
6. To have timely access to network providers
7. To participate in decision-making with providers regarding their own health care, including the right to refuse treatment
8. To voice grievances, either verbally or in writing, about the organization or the care they received
9. To know the medical reason for CalOptima Health's decision to deny, delay, terminate or change a request for medical care
10. To get care coordination
11. To ask for an appeal of decisions to deny, defer, or limit services or benefits
12. To get free interpreting and translation services for their language
13. To ask for free legal help at their local legal aid office or other groups
14. To formulate advance directives
15. To ask for a State Hearing if a service or benefit is denied and they have already filed an appeal with CalOptima Health and are still not happy with the decision, or if they did not get a decision on their appeal after 30 days, including information on the circumstances under which an expedited hearing is possible
16. To disenroll from CalOptima Health and change to another health plan in the county upon request
17. To access minor consent services
18. To get free written member information in other formats (such as braille, large-size print, audio and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (W&I) Code section 14182 (b)(12)
19. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
20. To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand, regardless of cost or coverage
21. To have access to and get a copy of their medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526

22. To freedom to exercise these rights without adversely affecting how they are treated by CalOptima Health, their providers or the state
23. To have access to family planning services, freestanding birth centers, FQHCs, Indian Health Care providers, midwifery services, RHCs, sexually transmitted infection services and emergency care outside CalOptima Health's network pursuant to federal law.

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 they 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 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 is required to inform its members of their rights and responsibilities and ensure those rights and responsibilities are respected and observed. OneCare provides this information to members annually in the Annual Notices and upon request.

CalOptima Health members have the right to:

- Choose a PCP in the CalOptima Health network
- See an in-network specialist without a referral
- Get covered services from network providers within a reasonable amount of time
  - This includes the right to get timely services from specialists
  - If services cannot be provided within a reasonable amount of time, CalOptima Health must pay for out-of-network care
- Get emergency services or care that's urgently needed without prior approval (PA)
- Get their prescriptions filled at any of our network pharmacies without long delays
- Know when they can use an out-of-network provider
- Keep their current providers and service authorizations for up to 12 months, if certain conditions are met, after first joining the plan.
- Make their own health care decisions with help from their care team and personal care coordinator

CalOptima Health members are responsible for:

- Reading the Member Handbook to learn what their plan covers and the rules to follow to get covered services and drugs
- Informing CalOptima Health and their providers about any other health or drug coverage they have
- Telling their doctor and other health care providers that they're OneCare members and showing their Member ID card when they get services or drugs
- Helping their doctors and other health care providers give them the best care
- Working with their personal care coordinator, including completing an annual health risk assessment
- Being considerate. CalOptima Health expects all plan members to respect the rights of others. We also expect them to act with respect in their doctor's office, hospitals and other provider offices
- Paying what they owe
- Telling CalOptima Health if they move
- Telling CalOptima Health if they have a new phone number or a better way to contact them
- Calling Customer Service for help if they have questions or concerns

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 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 upon enrolling. 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, COD-Administrative Medi-Cal/Medicare or CHCN, as described 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 PCP.

All Medi-Cal members receive an annual newsletter 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 Availability/Notice of Nondiscrimination
- 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 COD-Administrative Medi-Medi members within seven calendar days of the member becoming eligible with CalOptima Health.

Contents include:

- COD Welcome Letter
- CalOptima Health Medi-Cal ID Card
- COD New Member Orientation Invitation
- Notice of Availability/Notice of Nondiscrimination
- 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 COD-Administrative members within seven calendar days of the member becoming eligible with CalOptima Health.

Contents include:

- COD Welcome Letter
- CalOptima Health Medi-Cal ID Card
- COD New Member Orientation Invitation
- Notice of Availability/Notice of Nondiscrimination
- 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 Availability/Notice of Nondiscrimination
- 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 members receive two initial mailings that contain information to help them access OneCare's programs and services.

All members also receive an annual newsletter with articles on health education, service and benefit reminders, as well as 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. Notice of Privacy Practices
5. Notice of Availability/Notice of Nondiscrimination
6. Provider Directory and Formulary Electronic Format Insert
7. New Member Orientation Invitation
8. Silver & Fit Flyer
9. Liberty Dental Flyer and FAQ
10. OneCare ID Card (sent separately)

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 packet contents, 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 and its health networks to provide members who have limited proficiency in English with an interpreter or provider who speaks the member's primary language when members are seeking or obtaining care, 24/7. In addition, CalOptima Health and its health networks must meet requirements to provide linguistic services, including oral interpreters, American Sign Language interpreters, or bilingual providers and provider staff.

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 and its health networks to provide interpreter services to members with limited English proficiency 24/7. Limited English proficient (LEP) members include those who have a limited ability to read, speak, write or understand English. CalOptima Health and health networks must meet requirements to provide linguistic services, including oral interpreters, American Sign Language interpreters, or bilingual providers and provider staff.

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, CalOptima Health Community 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
AltaMed Health Services – AHN AltaMed Health Services	855-848-5252	855-848-5252
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 Services Family Choice Medical Group	800-611-0111	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	833-303-4551	833-303-4551 or fax request to 714-560-7305 Or submit a request online: www.prospectmedical.com
Providence	855-359-6323	855-359-6323
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 and its contracted health networks, medical groups and providers offer free interpreter services to limited English proficient (LEP) members 24/7. CalOptima Health and its contracted health networks must meet requirements to provide linguistic services, including oral interpreters, American Sign Language interpreters, or bilingual providers and provider staff. 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. All eligible CalOptima Health members are offered these benefits. 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

Members diagnosed with diabetes, asthma and congestive heart failure are enrolled in the CalOptima Health Disease Management Program. Newly identified members receive an introductory mailing that includes educational handouts and a 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 personalized goals and offer care coordination and education. In addition, members may receive an educational mailing package with 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 nonpregnant member, providers should complete a Health and Wellness Referral Form found at www.caloptima.org/en/for-providers/provider-common-forms 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 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 unnecessary services
- A member receiving services that are not medically necessary
- A provider billing for services not performed
- A provider submitting claims for duplicate services, unbundling or upcoding the claims
- 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
- A provider or provider's representative offering gifts or payments to obtain member information
- Falsifying records for an unauthorized purpose

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 to the government
- Conspiring to commit a violation of the above

Severe penalties for violations of the FCA may include civil penalties and/or criminal prosecution. The FCA protects employees, contractors and agents (whistleblowers) 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 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 **855-507-1805.** You may remain anonymous when calling the hotline.
- Send 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 policies HH.1105: Fraud, Waste and Abuse Detection and HH.1107: Fraud, Waste and Abuse Investigation and Reporting.

CalOptima Health's Special Investigation Unit (SIU) will investigate cases to determine if potential fraud or abuse exists, refer potential fraud and abuse cases to the appropriate entity, and document the process for each case. CalOptima 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 sources monthly to ensure 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 subcontracted 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 completed 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. Providing care for the majority of health care issues presented by the member, including preventive, acute and chronic health care.

2. Completing 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. Managing 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. Ensuring access to care 24/7, including accommodations for urgent care, procedures and hospitalizations.

5. Coordinating and directing appropriate care for members, including:
   a. Initial Health Assessment (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, as well as 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. Social Determinants of Health (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 (HRA)
      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 the American Academy of Pediatrics (AAP) and the United States Preventive Services Task Force (USPSTF).
g. Referrals and authorizations to specialists, DME, home health, long-term care, etc.
h. Coordination and continuity of primary and specialty care, DME, home health, long-term care, hospitalizations, etc.

6. Documenting follow-up and outreach to members who missed or canceled an appointment.

7. Recording and documenting 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. Supervising 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 system (COHS).
    a. When Schedule II drugs are furnished by a nurse practitioner (NP), certified nurse practitioner (CNP) and/or certified nurse midwife (CNM) with Drug Enforcement Agency (DEA) supervision by a physician is not required. The NP, CNP and/or CNM will 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. Communicating, 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, coordinating 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 a 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. Providing care for the majority of health care issues presented by the member, including preventive, acute and chronic health care.

2. Completing 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. Managing 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. Ensuring access to care 24/7, including accommodations for urgent care, procedures and hospitalizations.

5. Providing 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 in 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. Coordinating and directing appropriate care for members, including:
    a. 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 (DME), home health, long-term care, etc.
    d. Coordination and continuity of primary and specialty care, DMR, home health, long-term care, hospitalizations, etc.

7. Following up and reaching out to members who missed or canceled an appointment.

8. Recording and documenting 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. Supervising 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 (COHS).
    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, reflecting all aspects of the member's care. CalOptima Health will monitor a provider's compliance with maintaining a member's medical record during a medical record review. CalOptima Health will maintain confidentiality of the member's medical information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security policies, and additional applicable state and federal laws. Upon request, providers will provide access to a member who wishes to view their medical records.

ORGANIZATION OF MEDICAL RECORDS

Each provider will designate an individual responsible for the medical record system, which includes collecting, processing, maintaining, storing, retrieving, identifying, and distributing clinical information.

Active Records

1. A provider will label and file all active records in a defined system to facilitate the retrieval of a record on demand.
2. A provider will 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 will retain inactive records through the following process:
    a. For adult members, 10 years from the last date of service
    b. For pediatric members, for a minimum of 10 years or until the member's 19th birthday, but in no event for less than 10 years
3. For OneCare members, providers will 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 will be filed in the medical record within 48 hours after receipt, with the physician's signature and date of review, including but not limited to:
    a. Laboratory reports
    b. Diagnostic studies
    c. Imaging studies
    d. Electroencephalograms (EEGs) and echocardiograms (EKGs)
    e. Physical therapy, occupational therapy and speech therapy reports
    f. Home health and hospice reports
    g. Consultation reports
    h. Hospital records (admission/outpatient procedures)
    i. Emergency department records and urgent care reports

Any abnormal results and/or "STAT" reports will have an explicit notation including follow-up or outreach.

Member's Medical Record

1. CalOptima Health will 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 on 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 will 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 the advance directive information is offered.
2. A provider will establish an individual record for each member and update the record during each visit or encounter.
3. The record will be available in a legible, handwritten or typed format.
4. The record will reflect the findings of each visit or encounter.
5. Addenda to records will be clearly identified, signed and dated.

Authentication of Medical Record Entries

Every medical record entry will be dated and signed by each staff person or provider at each encounter. The signature will 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 will document the following in the member's medical record:

1. Date and time of missed appointment
2. All attempts to reach the member or authorized representative and the results of the follow-up actions
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 will be handled with strict confidentiality.
2. The medical records department manager or office manager is responsible for maintaining, monitoring and enforcing staff compliance in keeping member-related 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 will 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 will 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 will have the right to inspect or copy their PHI in a designated record set (DRS), upon verbal request, unless the provider specifically requires a written request. Providers will ensure that members have access to their medical records. The practitioner will 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 will 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 will 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 will provide a member with access to inspect or obtain a copy of their medical records, as outlined in CalOptima Health Policy GG.1618: Member Request for Medical Records.

A member, or the 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 will 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

R1: PROVIDER COMPLAINT PROCESS

Medi-Cal and OneCare maintain a provider complaint process to review and resolve provider payment disputes, utilization management-related provider appeals and other provider complaints, as applicable to the line of business, provider status and the entity responsible for the payment or determination.

CalOptima Health uses a one-level Provider Dispute Resolution (PDR) process when the dispute involves a claim determination made directly by CalOptima Health, including decisions made under CHCN or COD, where CalOptima Health is responsible for the payment.

This single-level PDR process does not replace or remove the other required dispute or appeal processes, including:

- Provider complaints for delegated health network determinations
- Medicare external appeal rights
- Dispute processes specific to Medi-Cal directed payment and quality program requirements

For Medi-Cal disputes involving data accuracy, quality measure performance rates or other data elements used for directed payment initiatives, Alternative Payment Methodology (APM) programs or other DHCS-required quality programs, CalOptima Health maintains a separate administrative provider complaint process. This process is distinct from claim payment, authorization or contractual disputes.

For disputes related to the Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP), including questions about qualifying bed-day calculations or payer responsibility, providers must follow the SNF WQIP grievance process and its associated payment instructions.

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 provider complaint process for disputes involving determinations made by a CalOptima Health-contracted health network or other delegated entity, as follows:

- **Level 1** complaints involve disputes regarding utilization management decisions, claims payment determinations or other actions taken by a CalOptima Health-contracted health network or another third-party administrator (TPA) responsible for the underlying determination. Level 1 complaints must be filed with the entity that issued the disputed determination.
- **Level 2** complaints are requests for a CalOptima Health review of a Level 1 complaint decision issued by a CalOptima Health-contracted health network or other TPA, when CalOptima Health offers a Level 2 review for that dispute type.

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 contracted through Medi-Cal or OneCare or is a noncontracted 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 Noncontracted Providers.

Contracted Providers

- To file a complaint with CalOptima Health, please complete a PDR Request Form and submit it to the entity that issued the disputed payment, denial or other determination. To obtain a copy of the PDR Request Form, visit the Providers section of the CalOptima Health website. Please see **Section R3: Required Documentation for Complaints** for tips on completing the form.
  - If the complaint involves a payment or determination rendered by a CalOptima Health-contracted health network or other delegated entity, submit the PDR Request Form to that entity. For health network contact information, see **Section B1: CalOptima Health Department and Program Contact Information**.
  - If the complaint involves a payment or determination rendered by CalOptima Health directly**,** submit the PDR Request Form to GARS. For more information on filing addresses, see **Section R4: Addresses for Filing Provider Complaints.**
- **Level 2** (applicable to delegated health network disputes, not CalOptima Health direct one-level PDR) — If you are not satisfied with the outcome of a Level 1 complaint issued by a CalOptima Health-contracted health network or delegated entity, you can file a Level 2 complaint with GARS, as applicable. 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.**
- For Medi-Cal directed payment initiative, APM or other DHCS-required quality program disputes involving data accuracy, quality measure performance rates or related data elements, providers must submit the dispute through the CalOptima Health administrative provider complaint process designated for those programs, including any program-specific subject matter expert or inbox identified by CalOptima Health.
- For SNF WQIP-related grievances, including disputes regarding directed payments, qualifying bed-day calculations, payment processing or responsible payer determination, eligible network providers must use the designated SNF WQIP grievance process and related contact information published by CalOptima Health.

Noncontracted Providers

- To file a complaint, complete a PDR 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 completing the form.
- A noncontracted provider payment dispute must be filed with the entity that issued the payment, denial or notice of nonpayment.
  - 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 does not involve a PDR, submit the reconsideration request 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 65 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 NONCLAIMS ISSUES

Claims and Nonclaims Issues	Options Available to the Provider
Contracted/Noncontracted provider	If CalOptima Health is responsible for payment, file the payment dispute with GARS. File Level 1 PDR request with the health network. File Level 2 PDR 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 Nonclaims Issues	Options Available to the Provider
Contracted provider	If CalOptima Health is responsible for payment, file the payment dispute with GARS.

Claims and Nonclaims Issues	Options Available to the Provider
	File Level 1 PDR request with health network. File Level 2 PDR request with GARS. Legal claims and judicial review may be available. See CalOptima Health Policy AA.1217: Legal Claims and Judicial Review.
Noncontracted 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 PDR request with the health network that issues the payment. File a Level 2 PDR 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 30 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	65days 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 include 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, noncontracted 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 is not submitted within the time frame, the dispute/complaint will be closed without further action.
5. **Resolution** — Medi-Cal provider disputes 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. Contracted Medicare provider disputes are resolved within 30 calendar days from the date of receipt. Noncontracted 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.9006: Contracted Provider Complaint Process

MA.9009: Non-Contracted Provider Complaint Process

This section applies to the following CalOptima Health programs:

Medi-Cal, OneCare

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 contracted health network
- The complaint is related to a decision made by CalOptima Health or a contracted health network
- The complaint is a Level 1 (initial appeal or payment dispute) or Level 2 reconsideration request of a Level 1 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 nonclaim complaints related to decisions rendered by CalOptima Health-contracted health networks	Send to the applicable CalOptima Health-contracted health network See **Section B1: CalOptima Health Department and Program Contact Information**
Provider Payment Disputes (PDRs) CalOptima Health claim disputes related to decisions rendered by CalOptima Health	CalOptima Health Attention: Grievance and Appeals-PDR PO Box 57015 Irvine, CA 92619 **Provider Portal**: CalOptima Health PDRs should be submitted electronically through the CalOptima Health Provider Portal.
Noncontracted Provider Appeal Denials of payment for Medicare-covered services (A signed Waiver of Liability is required)	CalOptima Health Attention: Grievance and Appeals-Claim Appeal 505 City Parkway West Orange, CA 92868

Level of Dispute	Addresses
Level 1 and Level 2 Provider UM Appeals Post service authorization appeals for decisions made by CalOptima Health UM	CalOptima Health Attention: Grievance and Appeals-Post Service Authorization Appeal 505 City Parkway West Orange, CA 92868

Level 2 — Complaints

Level of Dispute	Addresses
Level 2 Health Network Payment Dispute and UM Appeal Contracted claim and retrospective authorization-related decisions rendered by the health network. *Level 2 provider payment disputes do not apply to CalOptima Health claims.	505 City Parkway West Orange, CA 92868
Level 2 — Noncontracted Medicare Provider Health Network Payment Dispute	505 City Parkway West Orange, CA 92868

Noncontracted Medicare Provider Appeal: If the denial is upheld or a decision is not rendered in 30 calendar days, CalOptima Health GARS will forward your appeal case to the Medicare independent review entity, Maximus Federal Services, 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 65 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:

GG.1510: Member Appeal Process

HH.1101: CalOptima Health Provider Complaint

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

R5: TIME FRAME FOR RESOLUTION OF COMPLAINTS — NONCONTRACTED PROVIDERS

Complaint resolution time frames for providers 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 noncontracted providers are set by Medicare and require a signed Waiver of Liability.

RESOLUTION TIME FRAMES FOR NONCONTRACTED PROVIDERS

Please use the table below to find the applicable resolution time frames by type of **noncontacted provider complaints:**

Type of Medicare Noncontracted Provider Complaint	Days	Review Entity
Provider Dispute Resolution Request — Payment amount in dispute	30 calendar days	The entity (health network or CalOptima Health) that issued the payment in dispute
Level 2 Health Network Provider Dispute Resolution Request — Payment amount in dispute	30 calendar 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 preservice appeal on behalf of the member, provided the member gives their written consent. Appeals must be requested within 60 calendar days of the date of the notice of denial for Medi-Cal and within 65 calendar days of the date of the notice of denial for 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 preservice appeal:

1. Notify the member that you are filing on their behalf and obtain written consent.

2. Within 60 calendar days of the date of the notice of denial for Medi-Cal and within 65 calendar days of the date of the notice of denial for OneCare:
    a. Call OneCare Customer Service at **855-705-8823** 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 preservice appeal:

1. Notify the member that you are filing on their behalf and obtain written consent.

2. Within 60 calendar days of the date of the notice of denial for Medi-Cal and within 65 calendar days of the date of the notice of denial for OneCare, call OneCare Customer Service at **855-705-8**823 or Medi-Cal Customer Service at **888-587-8088** and request the appeal.

Member Complaint Form — Providers may use the Member Complaint Form to file the appeal on the 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 their 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:

GG.1510 & MA.9015: Standard Service Appeal

GG.1510 & MA.9004: Expedited Service Appeal

MA.9005: Payment Appeals

This section applies to the following CalOptima Health programs:

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

R7: 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 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 that 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 follows a Participant Bill of Rights.

The staff at CalOptima Health PACE make participants aware of their rights in three formats:

a. A separate document provided 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

RESPECT

Participants have the right to be treated with dignity and respect at all times, to have all their care kept private and confidential, and to get compassionate, considerate care. They have the right:

1. To get all their health care in a safe, clean environment and in an accessible manner.
2. To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed alone against their will, and any physical or chemical restraint that is used for discipline or convenience of staff and that they do not need to treat their medical symptoms.
3. To be encouraged and helped to use their rights in the PACE program.
4. To receive help, if needed, on how to use the Medicare and Medi-Cal complaint and appeal processes, as well as to understand their civil and other legal rights.
5. To be encouraged and helped in talking to PACE staff about changes in policy and services they think should be made.
6. To use a telephone while at the CalOptima Health PACE Center.
7. To not have to do work or services for the PACE program.
8. To have all information about their choices for PACE services and treatment explained to them in a language they understand, and in a way that takes into account and respects their cultural beliefs, values and customs.

PROTECTION AGAINST DISCRIMINATION

Discrimination is against the law. Every company or agency that works with Medicare and Medi-Cal must obey the law. They cannot discriminate against participants because of their:

1. Race
2. Ethnicity
3. National origin
4. Religion
5. Age
6. Sex
7. Mental or physical disability
8. Sexual orientation
9. Source of payment for their health care (e.g., Medicare or Medi-Cal)

If participants think they have been discriminated against for any of these reasons, they may contact a staff member at the PACE program to help resolve their problem. If they have any questions, they can call the Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697).

INFORMATION AND ASSISTANCE

Participants have the right to get accurate, easy-to-understand information, to have this information shared with their designated representative, who is the person they choose to act on their behalf, and to have someone help them make informed health care decisions. They have the right:

1. To have someone help them if they have a language or communication barrier, so they can understand all information given to them.

2. To have the PACE program interpret the information into their preferred language in a culturally competent manner, if their first language is not English and they can't speak English well enough to understand the information being given to them.
3. To get marketing materials and PACE participant rights in English and in any other frequently used language in their community. They can also get these materials in Braille, if necessary.
4. To have the Enrollment Agreement fully explained to them in a manner understood by them.
5. To get a written copy of their rights from the PACE program. The PACE program must also post these rights in a public area of the PACE Center where they are easily seen.
6. To be fully informed, in writing, of the services offered by the PACE program. This includes telling them which services are provided by contractors instead of the PACE staff. They must be given this information before they join, at the time they join and when they need to make a choice about which services to receive.
7. To be provided, upon request, with a list of individuals who provide care-related services not provided directly by CalOptima Health PACE.
8. To look at, or get help to look at, the results of the most recent review of their PACE program. Federal and state agencies review all PACE programs. They also have the right to review how the PACE program plans to correct any problems found during inspection.
9. Before CalOptima Health PACE starts providing palliative care, comfort care and end-of-life care services, participants have the right to have information about these services fully explained to them. This includes their right to be given, in writing, a complete description of these services and how they are different from the care they have been receiving, and whether these services are in addition to or instead of their current services. The information must also explain, in detail, how their current services will be impacted if they choose to begin palliative care, comfort care or end-of-life services, including but not limited to, the impact to the following services. Specifically, it must explain any impact to:
    - Physician services, including specialist services
    - Hospital services
    - Long-term care services
    - Nursing services
    - Social services
    - Dietary services
    - Transportation
    - Home care
    - Therapy, including physical, occupational and speech therapy
    - Behavioral health
    - Diagnostic testing, including imaging and laboratory services
    - Medications
    - Preventive health care services
    - PACE center attendance

Participants have the right to change their mind and revoke their consent to receive palliative care, comfort care or end-of-life care services at any time and for any reason by letting CalOptima Health PACE know either verbally or in writing.

CHOICE OF PROVIDERS

Participants have the right to choose a health care provider, including their primary care provider and specialists, from within the PACE program's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

Participants have the right to have reasonable and timely access to specialists as indicated by their health condition.

They also have the right to receive care across all care settings, up to and including placement in a long-term care facility when CalOptima Health PACE can no longer maintain them safely in the community.

PARTICIPATION IN TREATMENT DECISIONS

Participants have the right to fully participate in all decisions related to their care. If they cannot fully participate in their treatment decisions or want to have someone they trust help them, they have the right to choose that person to act on their behalf. They also have the right:

1. To have all treatment options explained in a language they understand, to be fully informed of their health status and how well they are doing, and to make health care decisions. This includes the right not to get treatment or take medications. If they choose not to get treatment, they must be told how this will affect their health.
2. To fully understand CalOptima Health's palliative care, comfort care and end-of-life care services. Before CalOptima Health can start providing palliative care, comfort care and end-of-life care services, the PACE program must explain all treatment options, give participants written information about these options and get written consent from the participant or their designated representative.
3. To have the PACE program help them create an advance directive if they choose. An advance directive is a written document stating how they want medical decisions to be made in case they cannot speak for themselves. Participants should give it to the person who will carry out their instructions and make health care decisions for them.
4. To participate in making and carrying out their plan of care. They can ask for their plan of care to be reviewed at any time.
5. To be given advance notice, in writing, of any plan to move them to another treatment setting and the reason they are being moved.

CONFIDENTIALITY OF HEALTH INFORMATION

CalOptima Health PACE participants have the right:

1. To talk with their health care provider in private and have their personal health care information kept private and confidential, including health data that is collected and kept electronically, as protected under state and federal laws.
2. To look at and receive copies of their medical records and request amendments.
3. To be assured their written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.
4. To provide written consent that limits the degree of information and the persons to whom information may be given.

There is a patient privacy rule that gives participants more access to their own medical records and more control over how their personal health information is used. If they have any questions about this privacy rule, they can call the Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697).

COMPLAINTS

Participants have the right to complain about the services they receive, the services they need and don't receive, the quality of their care, or any other concerns or problems they have with their PACE program. They have the right to a fair and timely process for resolving concerns with the PACE program. Participants have the right specifically to:

1. To a full explanation of the complaint process.
2. To be encouraged and helped to freely explain their complaints to PACE staff and outside representatives of their choice. Participants must not be harmed in any way for telling someone their concerns. This includes being punished, threatened or discriminated against.
3. To contact 1-800-MEDICARE (1-800-633-4227) 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** for more information about the participant grievance process.

REQUESTING ADDITIONAL SERVICES OR FILING APPEALS

Participants have the right to request services from CalOptima Health PACE, its employees or contractors that they believe are necessary. They have the right to a comprehensive and timely process for determining whether those services should be provided.

They also have the right to appeal any denial of a service or treatment decision by the PACE program, staff or contractors.

Refer to Section **S4: Participant Appeal Process** for more information about the participant appeals process.

LEAVING THE PROGRAM

If, for any reason, they do not feel the PACE program is what they want, participants have the right to leave the program at any time and have such disenrollment be effective the first day of the month following the date CalOptima Health PACE receives their notice of voluntary disenrollment.

Additional Help: If they feel any of their rights have been violated, or they are dissatisfied and want to file a grievance or an appeal, participants should report this immediately to their social worker or call our office during regular business hours at:

1-714-468-1100 or toll-free **1-844-999-PACE** (7223).

If they would like to talk to someone outside of CalOptima Health PACE about their concerns, they may contact 1-800-MEDICARE (1-800-633-4227) or 1-888-804-3536 (Health Consumer Alliance - Medi-Cal Ombudsman Program).

PARTICIPANT RESPONSIBILITIES

We believe that participants and family members or caregivers involved in their care play crucial roles in the delivery of care. To ensure they remain as healthy and independent as possible, participants should establish an open line of communication with those participating in their care and be accountable for the responsibilities listed below:

- Cooperate with the IDT in implementing and following their care plan.

- Discuss with their providers if they do not want to accept a treatment or medication their IDT decides they need, and to understand and accept the consequences to their health and well-being if they refuse any recommended treatment.
- 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, whether in or 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 and without discrimination of any kind.
- Not ask staff to perform tasks they are prohibited from doing 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

Everyone in the PACE program shares responsibility for participants' care and their satisfaction with the services they receive. PACE grievance procedures are designed to enable participants and/or their representatives to express any concerns or dissatisfaction so we can address them in a timely and efficient manner. At any time, should they wish to file a grievance, PACE staff are available to assist them. If they do not speak English, a bilingual staff member or translation services will be available to assist with the process.

Participants will not be discriminated against because a grievance has been filed. PACE will continue to provide all required services during the grievance process. The confidentiality of the grievance will be maintained throughout the process, and information pertaining to the grievance will only be released to authorized individuals.

A grievance is defined as a complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of participant care, regardless of whether remedial action is requested. A grievance may include, but is not limited to:

- The quality of services a PACE participant receives in the home, at the PACE center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility or residential care facility)
- Waiting times on the phone, in the waiting room or exam room
- Behavior of any of the care providers or program staff
- Adequacy of center facilities
- Quality of the food provided
- Transportation services
- A violation of a participant's rights

A representative is the person who is acting on a participant's behalf or assisting them, and may include, but is not limited to, a family member, a friend, a PACE employee, or a person legally identified as power of attorney for health care/advanced directive, conservator, guardian, etc.

PACE has established a grievance process to address participants' concerns or dissatisfaction 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 filing 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 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 HIPAA regulations.

HOW PARTICIPANTS MAY FILE GRIEVANCES

1. Participants and/or their representative may voice a grievance to a PACE staff member in person, by telephone or in writing. While not required, participants may request a grievance form to use when submitting a written grievance.

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, participants may 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 can assist a participant and/or their 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 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 have 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 they are dissatisfied with the resolution, 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:

   Integrated Systems of Care Division (ISCD)
   ISCDCompliance@dhcs.ca.gov or
   PACE@dhcs.ca.gov

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 19-37
   Sacramento, CA 94244-2430
   Telephone: 1-800-952-5253
   Fax: 916 229-4410
   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 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 dissatisfaction they may have so that PACE can 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 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 IDT regarding a request for a service or payment of a service. An appeal is defined as 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 are available at any time to assist a participant who wishes to file an appeal. If the participant does not speak English, a bilingual staff member or translation service will be available to them.

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 throughout and after the appeals process. This includes, but is not limited to, transmission of appeal information between PACE staff members in adherence with 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. That 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 or PACE Quality Improvement department: **714-468-1100**

5. A participant and/or their representative may file a written appeal at either of the following locations:
    a. A PACE center at which the member is enrolled
    b. CalOptima Health PACE
    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 will maintain a toll-free number for filing an appeal, **855-785-2584** (TDD/TTY **714-468-1063**).

FILING AN APPEAL

1. The appeal process is available to any participant, their representative or their treating provider who disputes the denial of payment or the denial, deferral or modification of a service by the 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 will 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 they may be liable for the cost of the contested service if the determination is not made in their favor.

5. Under the circumstances listed above, PACE will not discontinue the disputed service for which an appeal was filed until the appeal process concludes.

6. The PACE Quality Improvement department will 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 will inform the participant or their 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 their additional appeal rights, as applicable.

8. PACE will 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, their 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 will take all reasonable steps to contact the participant, their 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 their representatives, will be given written notice of the appeals process and a 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 will 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, if the participant believes their life, health or ability to get well is in danger without the service they want, they or any treating physician may ask for an expedited appeal. If the treating physician asks for an expedited appeal for the participant or supports them in asking for one, PACE will automatically make a decision on their appeal as promptly as their health requires, but no later than 72 hours after PACE receives the request for an appeal. PACE may extend this time frame up to 14 calendar days if the participant asks for the extension or if PACE justifies to DHCS the need for more information and how the delay benefits the participant.

    If the participant asks for an expedited appeal **without** support from a treating doctor, PACE will determine whether their health condition requires an expedited decision. If PACE decides to deny an expedited appeal, PACE will let the participant know within 72 hours. If this happens, their appeal will be considered a standard appeal.

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 will apply:
    a. The PACE Quality Improvement department will 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 will 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.
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 will apply:
    a. Notice of any denial must:
        i. State the specific reasons for the denial.
        ii. Explain the reasons why the service would not improve or maintain the participant's overall health status.
        iii. Inform the participant of their 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 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Facsimile: 916-229-4410
TDD: 1-800-952-8349

1. PACE will not discontinue services for which an external appeal is filed until the external appeal process concludes.

2. If the participant and/or their representative decides to pursue a state hearing, they 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 of 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. 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
Grievances and Appeals
PO Box 57015
Irvine, CA 92619

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 claim payment disputes will be resolved within 30 calendar 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 7 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 if authorized by the IDT.

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.

Last Updated: 08/2026

Health Equity Fundamentals

1. Introduction

1.1 Welcome to Health Equity Fundamentals)

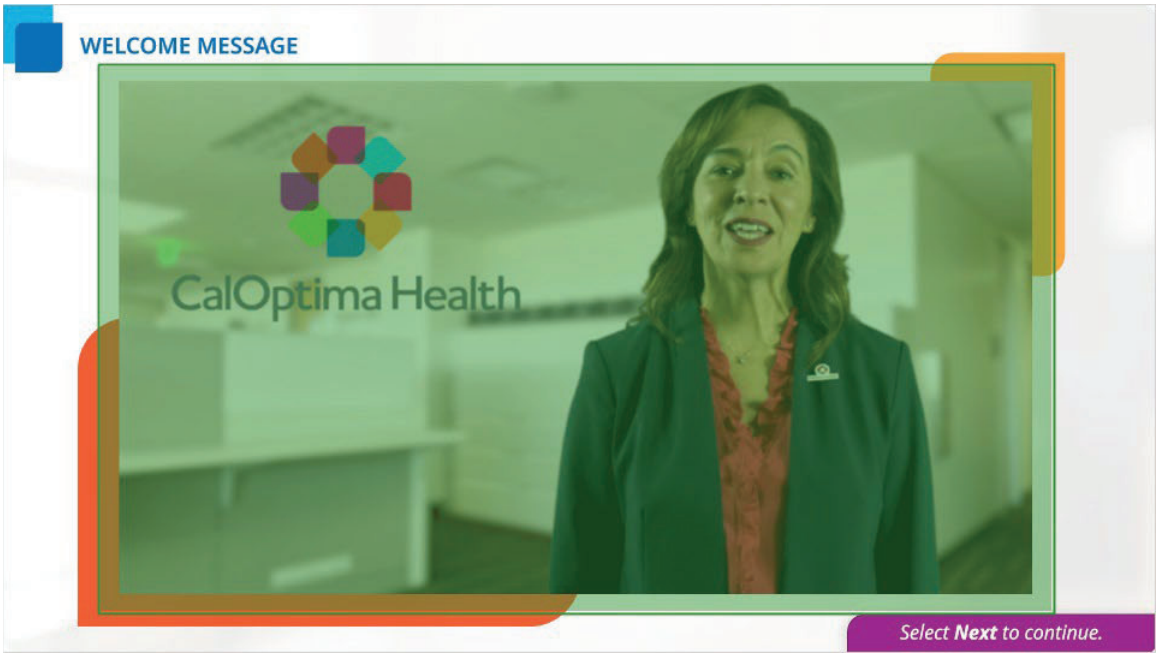


Notes:

Welcome to health equity fundamentals provided by CalOptima Health.

Please select NEXT, located in the bottom right of this media player, to continue.

1.3 Welcome Message



Notes:

Hello, my name is Dr. Michaell Silva Rose, CalOptima Health's Chief Health Equity Officer. I'm proud to welcome you to our Fundamentals of Health Equity module.

CalOptima Health is dedicated to ensuring that every member has an opportunity to achieve optimal health, regardless of their background or life circumstances. And for me, this commitment is personal. I imagine you have your own story about why you chose to work in healthcare and why you answered the call to serve our community. I am grateful that you did.

This third module is another step in our health equity learning journey. By having this shared knowledge and insight, we can work together as a team to ensure that fair, just, and equitable care is provided to all CalOptima Health members.

CalOptima Health has designed this module to ensure everyone gains an understanding of the definitions and fundamental concepts of health equity. We will share practical knowledge and key insights to help you provide the care our members need and deserve. I encourage you to be self-reflective and curious, and to always lead with kindness.

Thank you for all that you do and for your commitment to helping CalOptima Health deliver the highest quality of care for our members. It is a privilege to serve our community with you.

And with that, welcome to Fundamentals of Health Equity.

1.4 The Learning Roadmap for This Course



Notes:

In this module focused on health equity, we will cover four lessons:

Lesson 1: Defining and Striving for Health Equity
Lesson 2: Social Determinants of Health, Risk Factors, and Needs
Lesson 3: Health Inequity and Disparities
Lesson 4: Achieving Health Equity Together

1.5 The Learning Goals for This Course



Notes:

The learning goals for this module:

Our focus is on reinforcing and expanding your existing knowledge of the social, economic, and political factors that contribute to health outcomes and inequalities. By the end of the module, you should be able to:

1. Define health equity and describe its importance to CalOptima Health's members and community.
2. Identify social determinants of health that contribute to health outcomes.
3. Describe health inequities, health disparities, and the ways in which they impact marginalized communities.
4. Explore individual and collective actions to create greater health equity for CalOptima Health's members and community.

2. Lesson 1

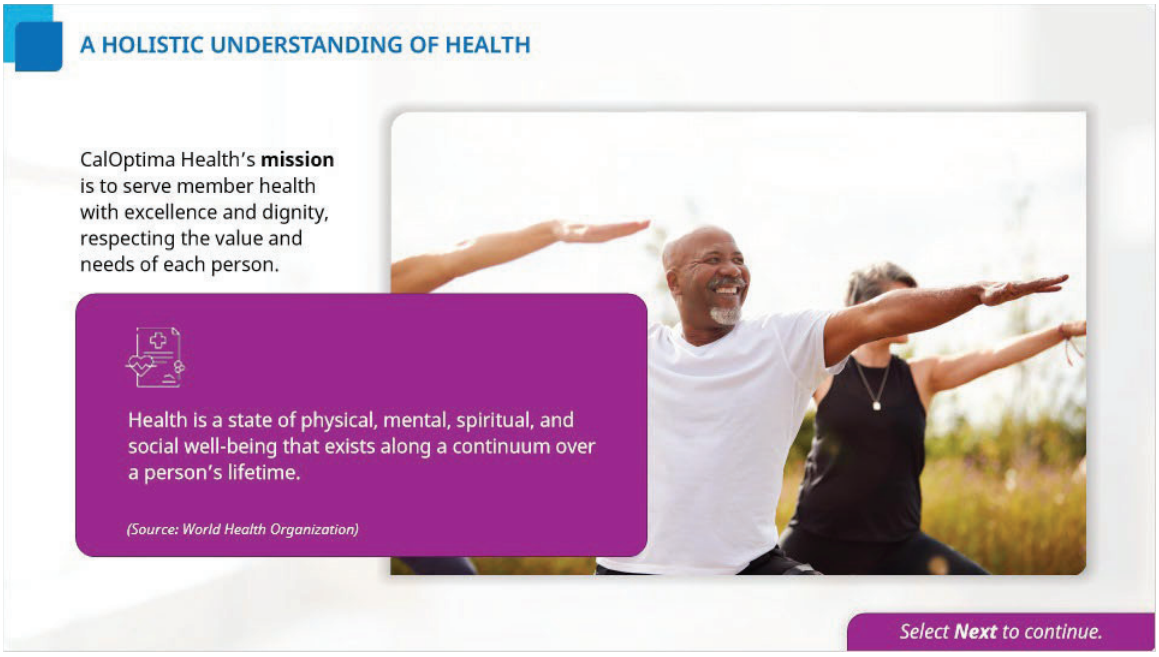
2.1 Lesson 1: Defining and Striving for Health Equity



Notes:

Lesson 1: Defining and Striving for Health Equity.

2.2 A Holistic Understanding of Health



Notes:

A holistic understanding of health: CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person.

Health encompasses more than just physical health and the absence of illness. It also refers to mental, emotional, spiritual, and social health and wellbeing.

Many factors influence whether or not a person will be healthy. Some relate to biological makeup or heredity, but many relate to the circumstances and conditions of a person's life.

3. Lesson 2

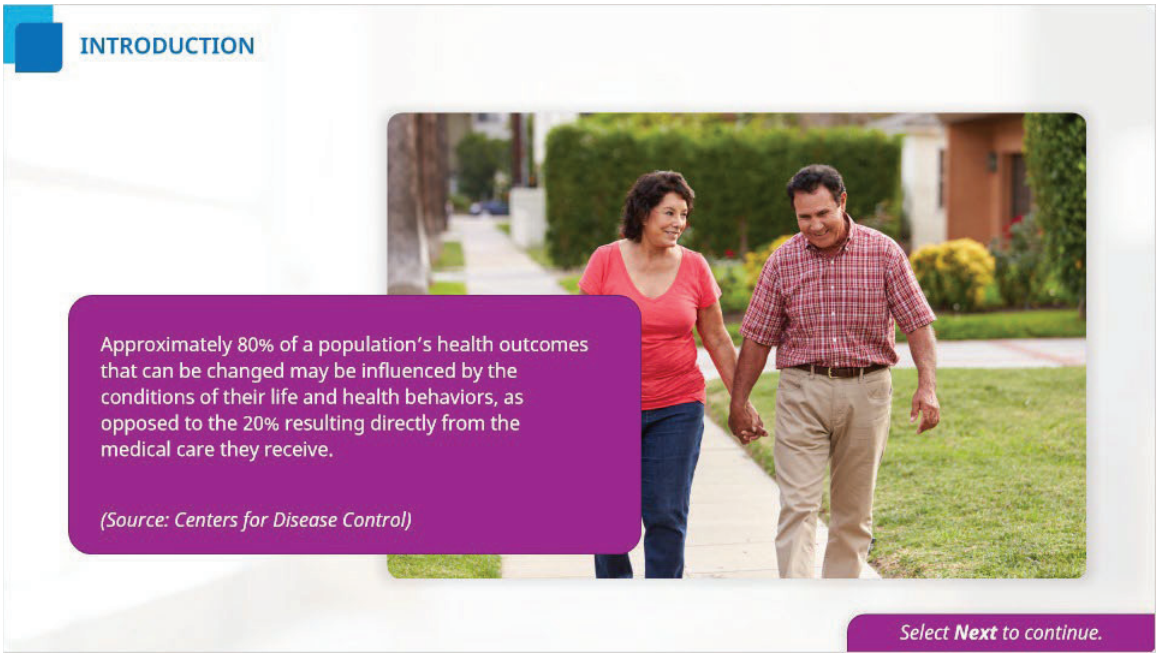
3.1 Lesson 2: Social Factors That Affect Health



Notes:

Lesson 2: Social Factors That Affect Health.

3.2 Introduction



Notes:

Introduction: In Lesson 1, we established that many factors in addition to medical care can affect people's health for better or worse. In fact, the Center for Disease Control estimates that approximately 80% of a person's health outcomes may be influenced by the conditions of their life and health behaviors, as opposed to the 20% resulting directly from the medical care they receive.

So, in order to help our members achieve their full health potential, we must consider and address the condition and circumstances of their daily lives.

We do this by considering social determinants of health, social risk factors, and social needs. The three concepts are related, but distinct.

3.3 Defining Social Determinants of Health, Social Risk Factors, and Social Needs

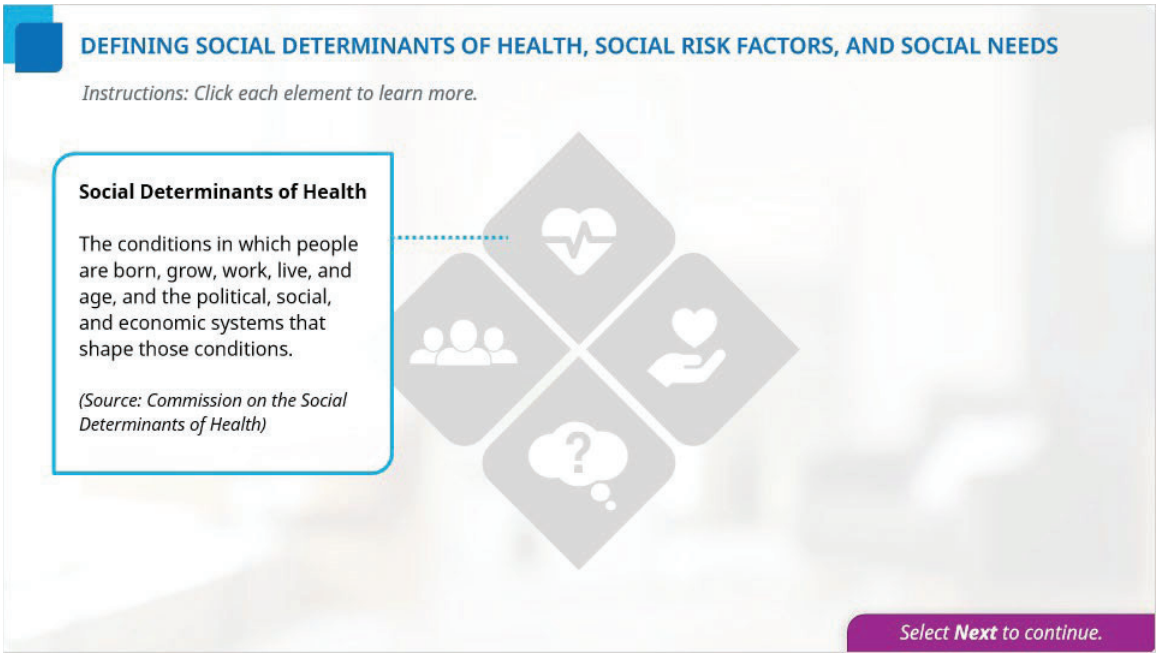


Notes:

Defining Social Determinants of Health, Social Risk Factors, and Social Needs

Instructions: Click each element to learn more.

L1: Social Determinants of Health (Slide Layer)



Notes:

Social determinants of health are the conditions in which people are born, grow, work, live, and age, and the political, social, and economic systems that shape those conditions. Social determinants of health are neither negative nor positive. Social factors-whether economic stability, social relationships, or employment status-can either enhance or reduce people's capacity to be healthy and shape an individual's health behaviors.

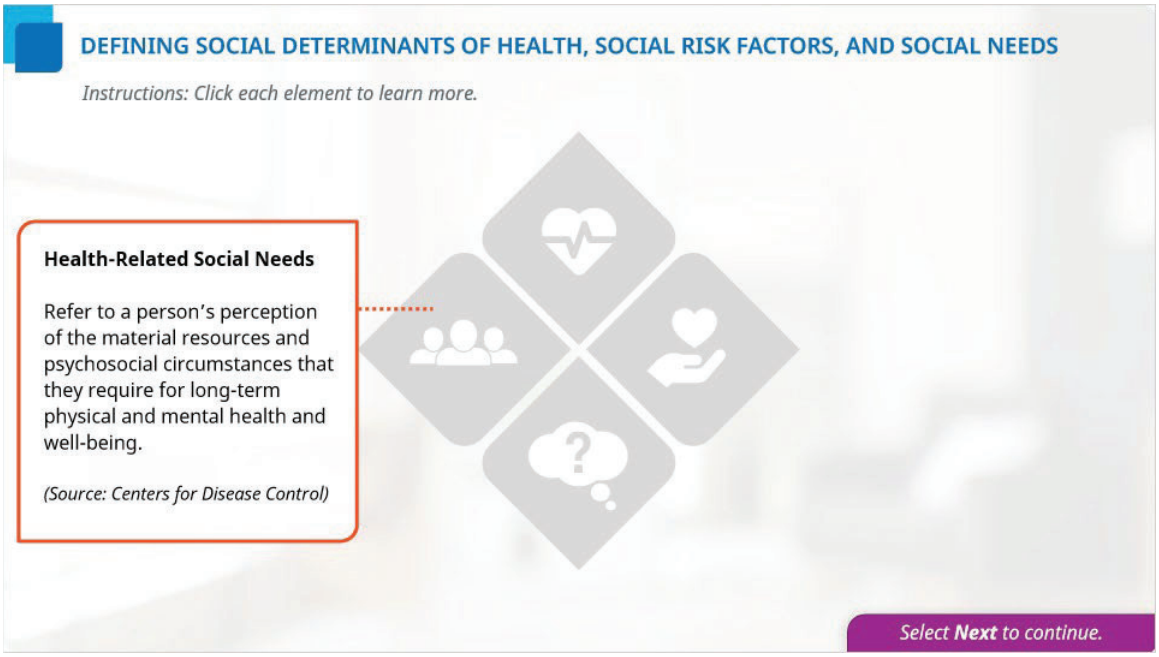
L2: Social Risk Factors (Slide Layer)



Notes:

Social risk factors are adverse social conditions that can be barriers to a person's health or health care, such as food insecurity and housing instability. Social risk factors are always considered to have negative impacts on a person's health and health care.

L3: Health Related Social Needs (Slide Layer)



Notes:

Health-related social needs are a person's perception of the material resources and psychosocial circumstances that they require for long-term physical and mental health and well-being. The needs are subjective and based on the individual's assessment. For example, a patient may be experiencing multiple social risks, such as a lack of access to transportation and healthy food, but, when asked, the patient may disclose that her most pressing social need is to find a safe place to stay away from a violent partner. Failing to understand the patient's perspective can and often does detract from finding the most effective immediate treatment.

L4: Interrelationship (Slide Layer)



Notes:

One way to think about the interrelationship of social determinants of health, social risk factors, and social needs is that, to achieve health equity, we must consider and assess social determinants of health, mitigate social risk factors, and address people's health-related social needs, since all three impact a person's ability to participate in health promotion.

3.4 The Five Categories of Social Determinants of Health



Notes:

The Five Categories of Social Determinants of Health

Because so many nonmedical factors affect our health - from where we live to how we earn money to whether we can afford health care - it helps to organize social determinants of health in categories.

The five categories of SDoH codified by the Center for Disease Control and adopted by many health care and public health organizations include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

Let's take a deeper look at the Five Categories of Health. Select each to learn more.

Economic Stability (Slide Layer)



Notes:

Economic stability means that individuals can afford necessities such as healthy food, health care, and safe housing. Employment opportunities, job training programs, career counseling, and accessible childcare are essential factors that enhance economic stability within communities.

Education (Slide Layer)



Notes:

Education Access and Quality: Research shows that people with higher levels of education are more likely to be healthier and live longer. This is because education is a resource that often creates access to further resources that support health like better jobs, higher income, and housing options. People with lower education may have less resources. They often work multiple jobs to make ends meet, so there is a lack of time for self care and health promotion. Initiatives that support academic achievement, language and literacy needs, and that provide financial assistance for education can contribute to improved long-term health outcomes.

Healthcare (Slide Layer)



Notes:

Healthcare Access and Quality: People's financial and physical access to health care, as well as their understanding of health services and their health, is a social determinant of health. This includes access to primary care, access to specialty care, health insurance coverage, and health literacy.

Neighborhood (Slide Layer)



Notes:

Neighborhood and Built Environment: Safe and healthy neighborhoods offer access to parks and safe sidewalks for walking and recreation, stores with affordable and available healthy food, and reliable transportation. These elements contribute to overall wellbeing and the ability to live healthily.

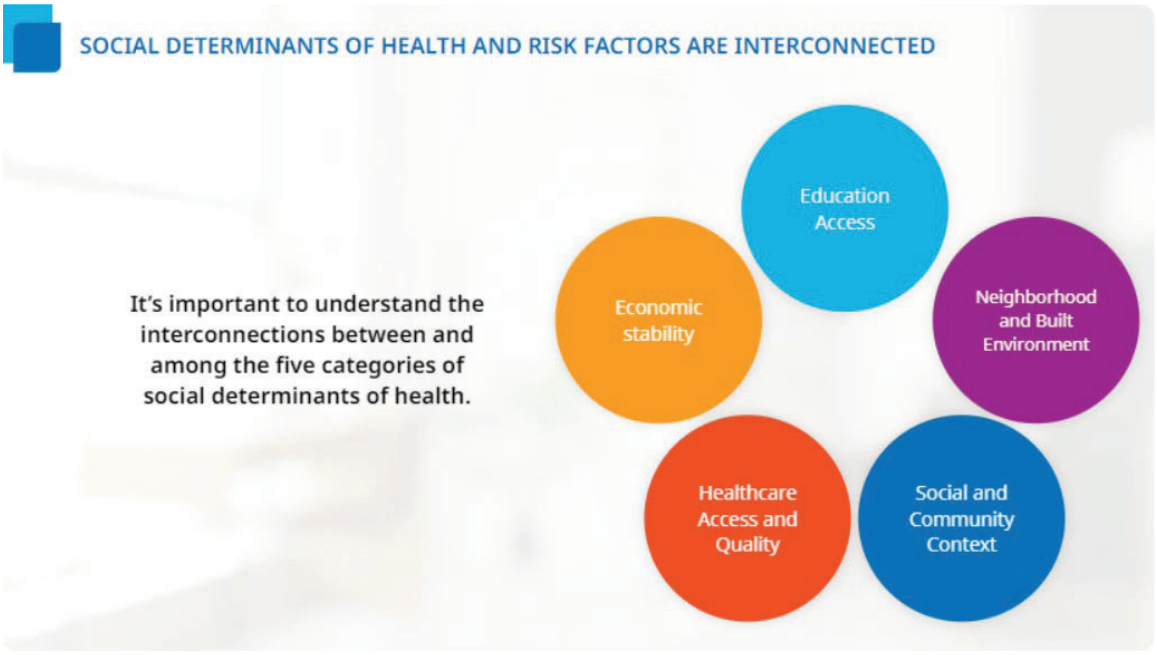
Social (Slide Layer)



Notes:

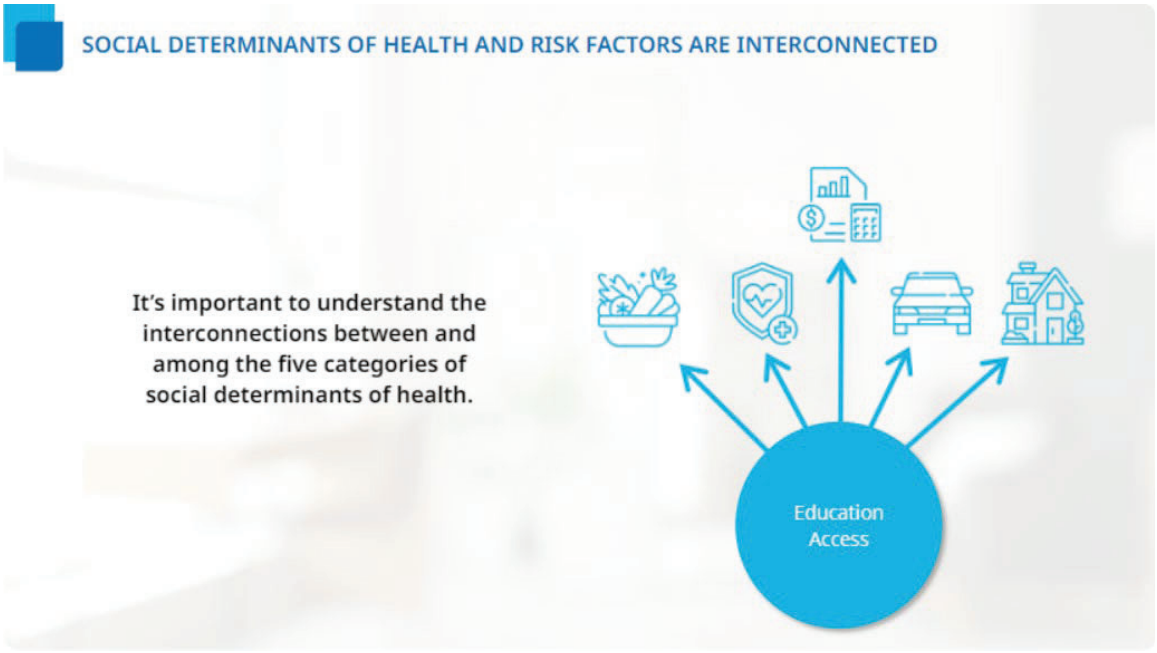
Social and Community Context: Relationships and connections with family, friends, coworkers, and community members profoundly impact health and wellbeing. Policies and programs that foster social and community support are vital for maintaining health and wellness.

3.5 Social Determinants of Health and Risk Factors Are Interconnected



Notes:

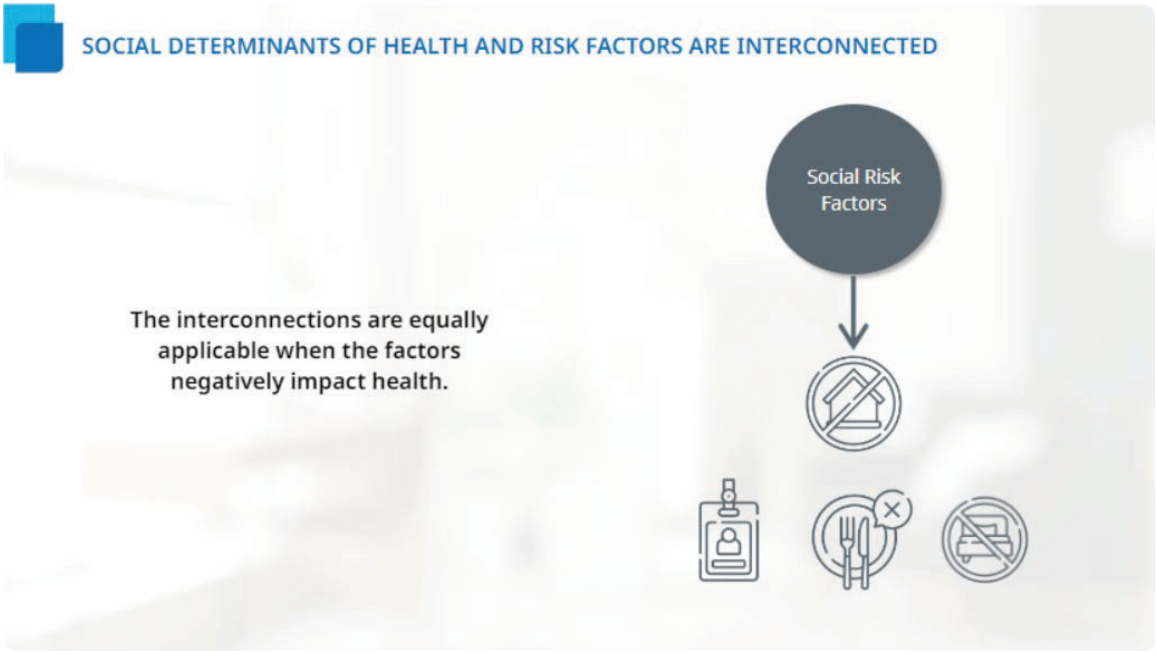
Social Determinants of Health and Risk Factors Are Interconnected.



Notes:

It is important to understand the interconnections between and among the five categories of social determinants of health. You just learned that, if a person benefits from access to quality education, it will likely enhance their health. Why? In addition to equipping them with skills to self-advocate for their health, a person's education creates access to resources like

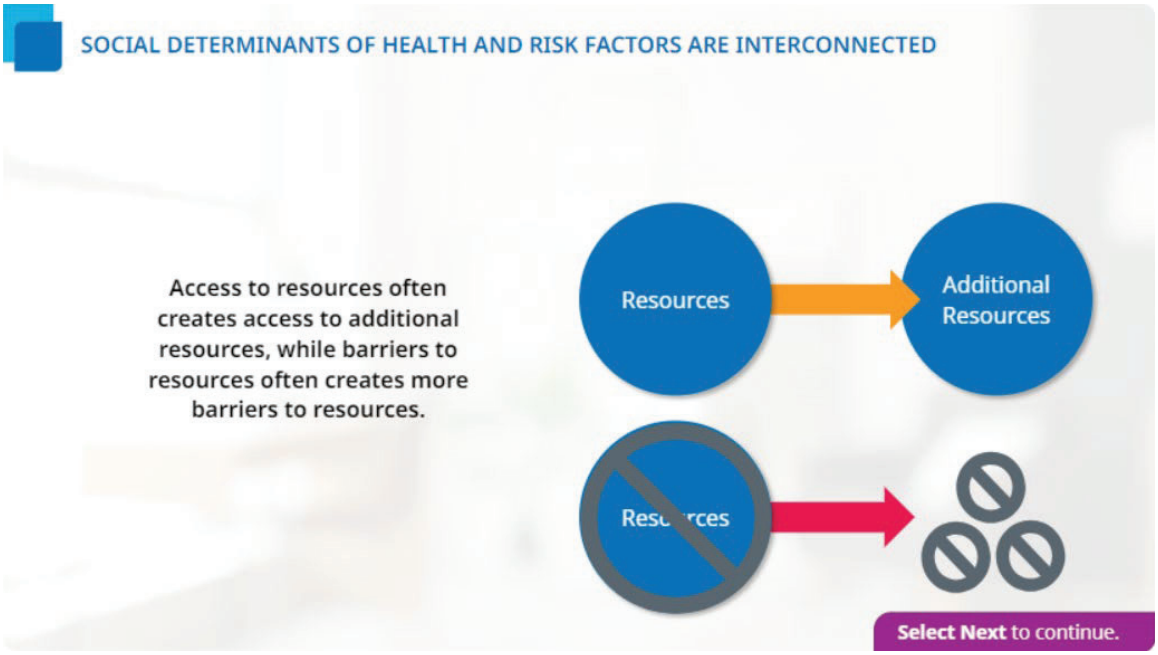
healthy food, reliable transportation, and housing options. Economic stability also decreases overall financial stress and worry.



Notes:

The interconnections are equally applicable when the factors negatively impact health. You will recall that adverse social circumstances associated with poor health, like food insecurity or housing instability, are called social risk factors. Social risks can negatively impact health in their own right, and they also tend to create additional, interconnected risks.

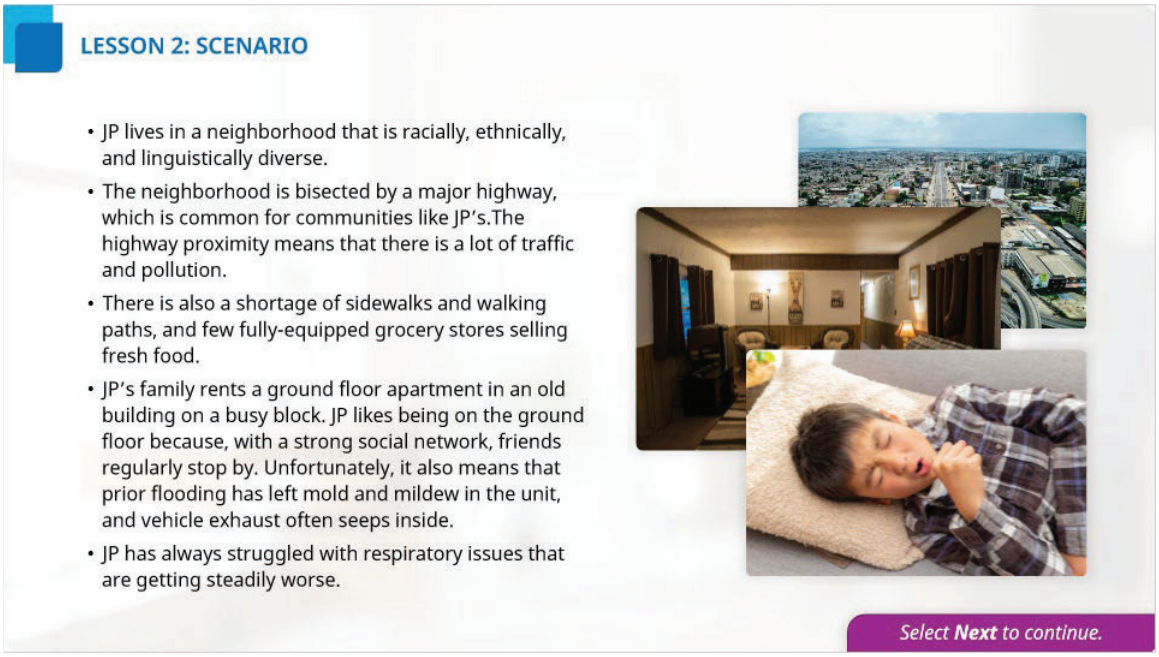
Let's use housing instability as an example. An individual without stable housing may find it difficult to maintain stable employment, may not have access to healthy food, and may be subjected to unsafe sleeping situations or environments.



Notes:

Access to resources often creates access to additional resources, while barriers to resources often creates more barriers to resources. Let's consider an example of how social determinants of health and social risks can impact health outcomes.

3.6 Lesson 2: Scenario



Notes:

Lesson 2 Scenario.

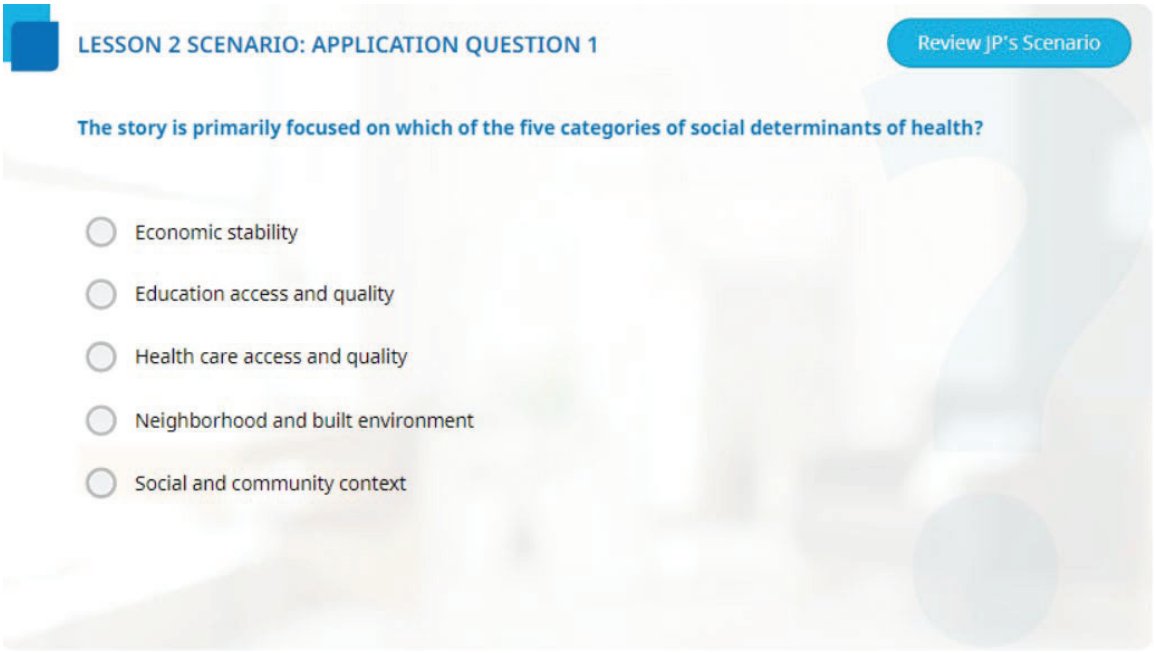
JP lives in a neighborhood that is racially, ethnically, and linguistically diverse. The neighborhood is bisected by a major highway, which is common for communities like JP's.

The highway proximity means that there is a lot of traffic and pollution. There is also a shortage of sidewalks and walking paths, and few fully-equipped grocery stores selling fresh food.

JP's family rents a ground floor apartment in an old building on a busy block. JP likes being on the ground floor because, with a strong social network, friends regularly stop by. Unfortunately, it also means that prior flooding has left mold and mildew in the unit, and vehicle exhaust often seeps inside.

JP has always struggled with respiratory issues that are getting steadily worse.

3.7 Lesson 2 Scenario: Application Question 1



Notes:

Answer the following questions about the scenario:

The story is primarily focused on which of the five categories of social determinants of health?

Select one answer then select SUBMIT.

Correct	Choice
	Economic stability
	Education access and quality
	Health care access and quality
X	Neighborhood and built environment
	Social and community context

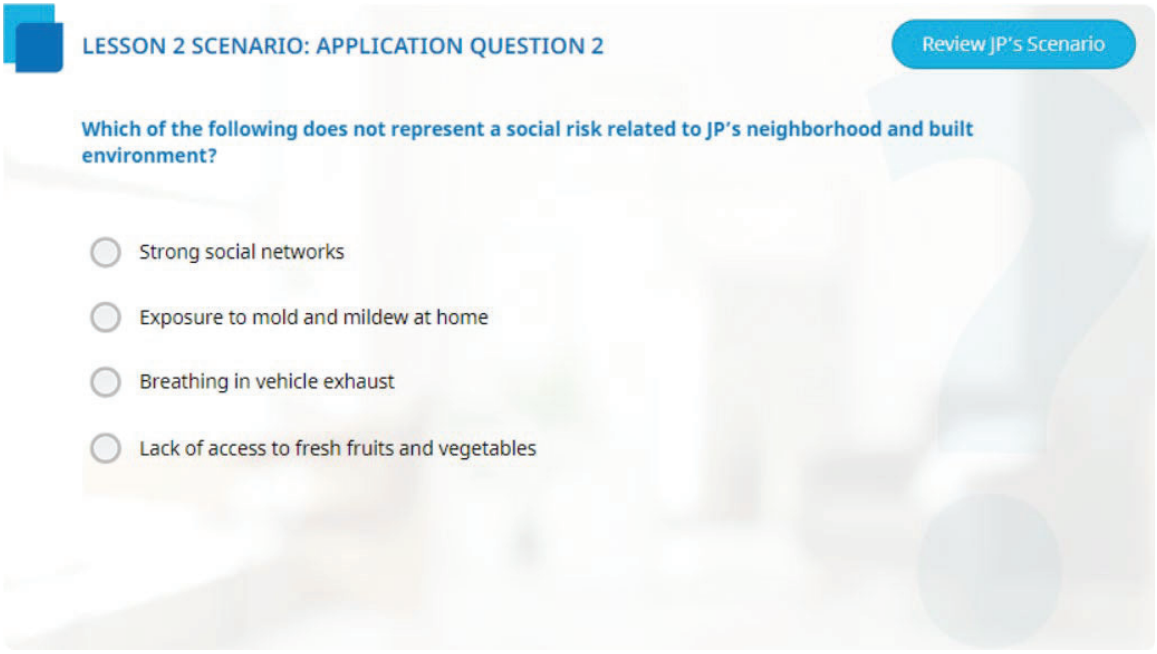
Feedback when correct:

Well done! The scenario focused on the building and neighborhood in which JP lives.

Feedback when incorrect:

Not quite. Your response should have been “neighborhood and built environment.” The scenario focused on the building and neighborhood in which JP lives.

3.8 Lesson 2 Scenario: Application Question 2



Notes:

Which of the following does not represent a social risk related to JP’s neighborhood and built environment?

Correct	Choice
X	Strong social networks
	Exposure to mold and mildew at home
	Breathing in vehicle exhaust
	Lack of access to fresh fruits and vegetables

Feedback when correct:

Well done! This question addressed social risk factors presented by the neighborhood and built environment. Exposure to mold and mildew at home, breathing in vehicle exhaust, and lack of access to fresh fruits and vegetables all represent social risks. JP has a strong social network, which is a social

determinant of health that can be positive for health outcomes instead of being a social risk, depending on the nature and quality of the friendships.

Feedback when incorrect:

Not quite. Sorry, that choice is incorrect. This question addressed social risk factors presented by the neighborhood and built environment. Exposure to mold and mildew at home, breathing in vehicle exhaust, and lack of access to fresh fruits and vegetables all represent social risks. The correct answer is that JP has a strong social network, which is a social determinant of health that can be positive for health outcomes instead of being a social risk, depending on the nature and quality of the friendships.

4. Lesson 3

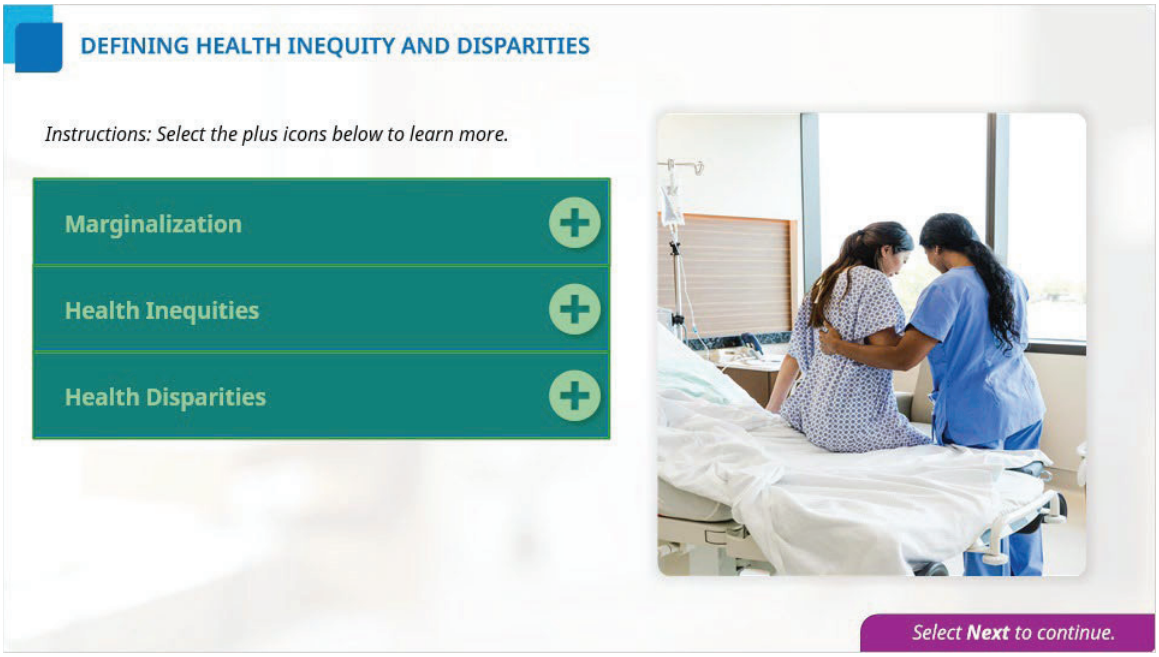
4.1 Lesson 3: Health Inequity and Disparities



Notes:

Lesson 3: Health Inequity and Disparities.

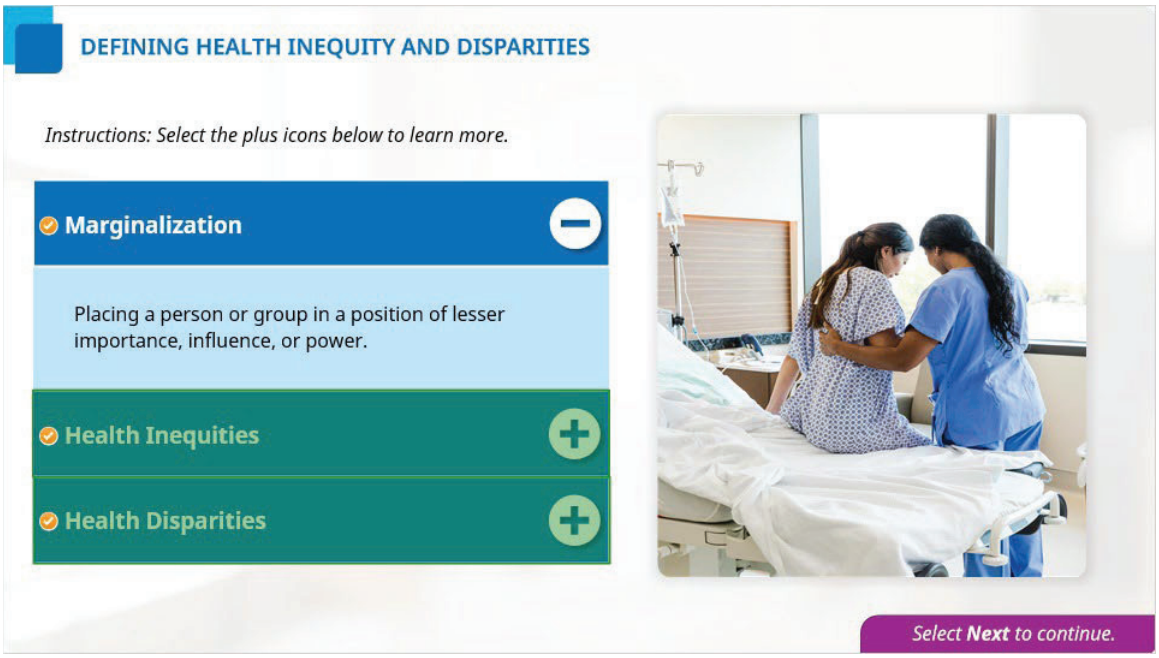
4.2 Defining Health Inequity and Disparities



Notes:

Defining health inequity and disparities. Select the plus icons below to learn more.

L1: Marginalization (Slide Layer)

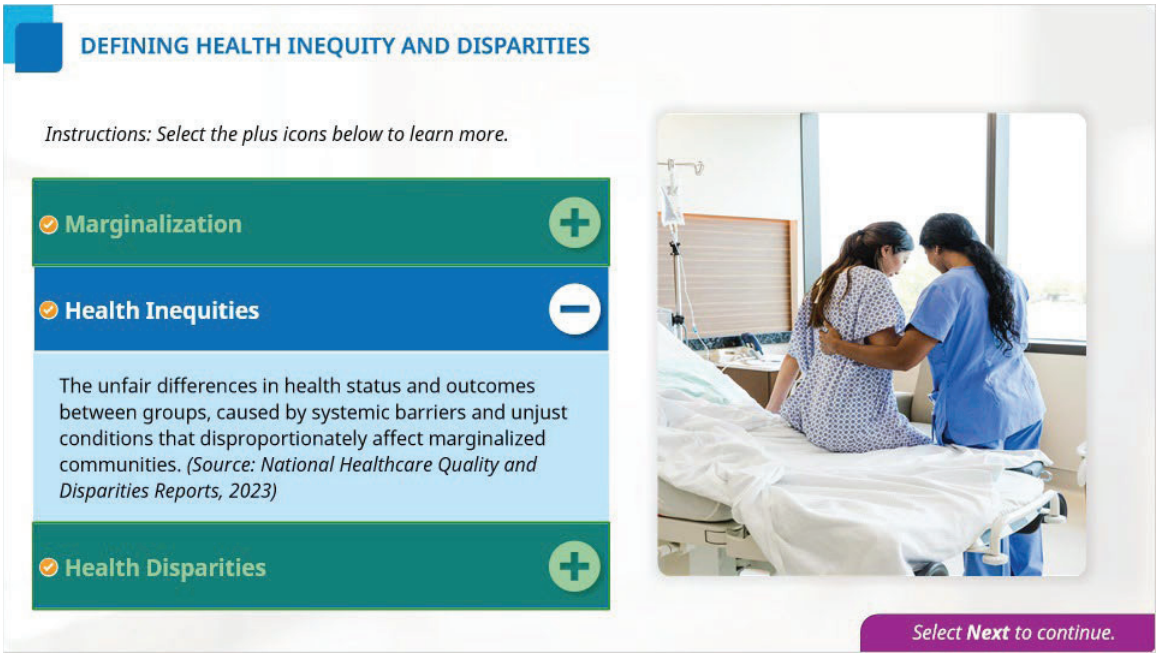


Notes:

Throughout history, various communities have received less opportunities, resources, and benefits than others, a status we

refer to as marginalization. These inequities extend to health.

L2: Health Inequities (Slide Layer)



Notes:

Health inequities are the unfair differences in health status and outcomes between groups, caused by systemic barriers and unjust conditions that disproportionately affect marginalized communities.

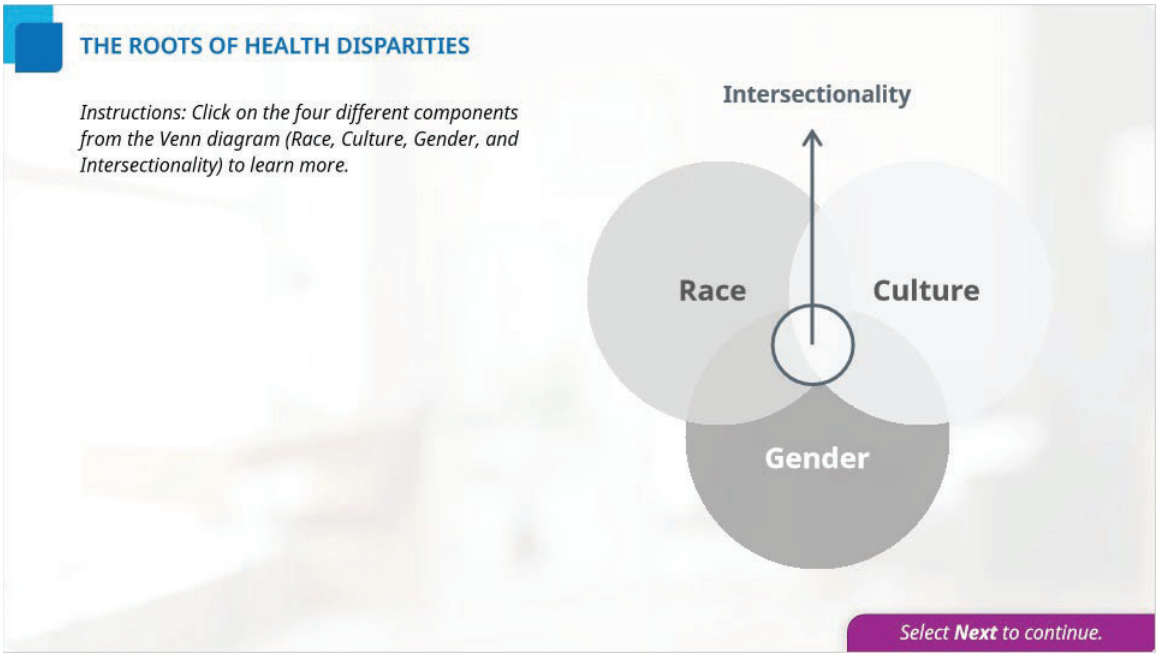
L3: Health Disparities (Slide Layer)



Notes:

When a group or population of individuals experience the same health inequities, it creates a health disparity. Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment.

4.3 The Roots of Health Disparities

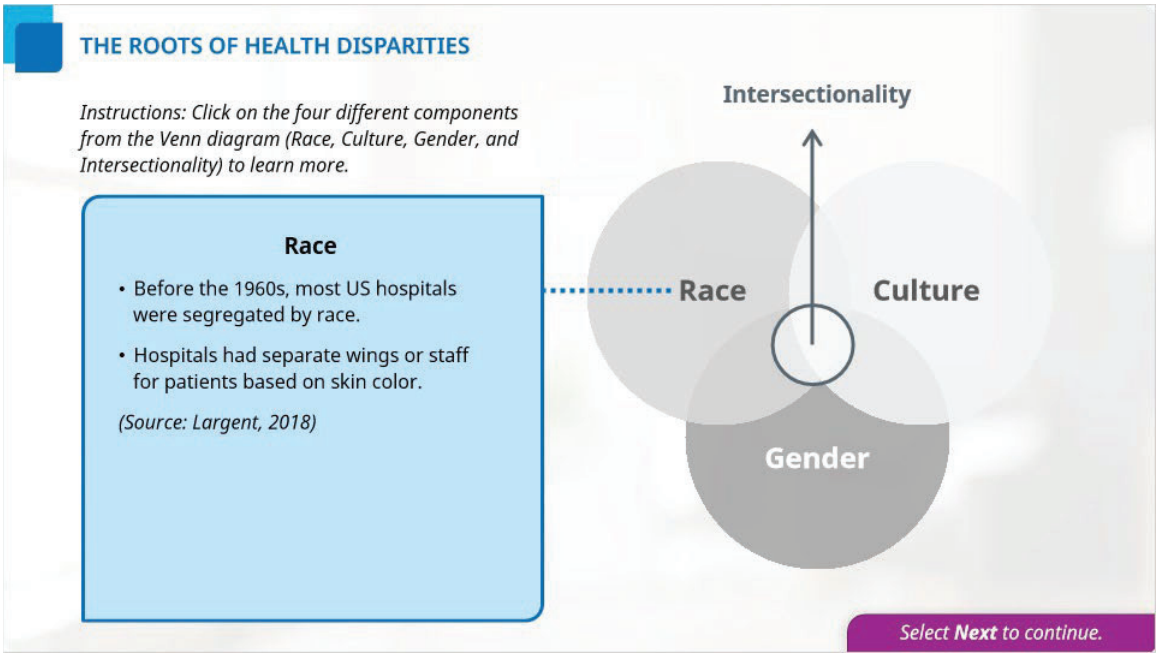


Notes:

Examples of historical inequity in health care include factors related to race, culture, and gender.

Click on the four different components from the Venn diagram to learn more.

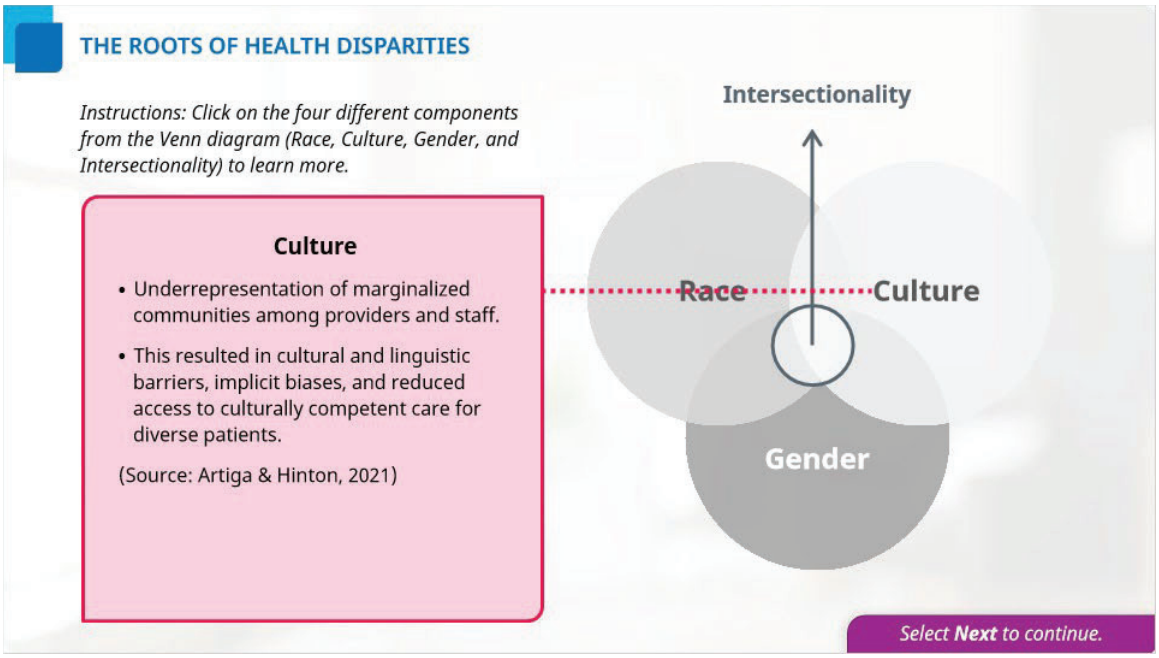
L1: Race (Slide Layer)



Notes:

Race: Prior to the 1960s, the vast majority of hospitals in the United States were segregated by race, or they had separate wings or staff for patients stratified according to skin color.

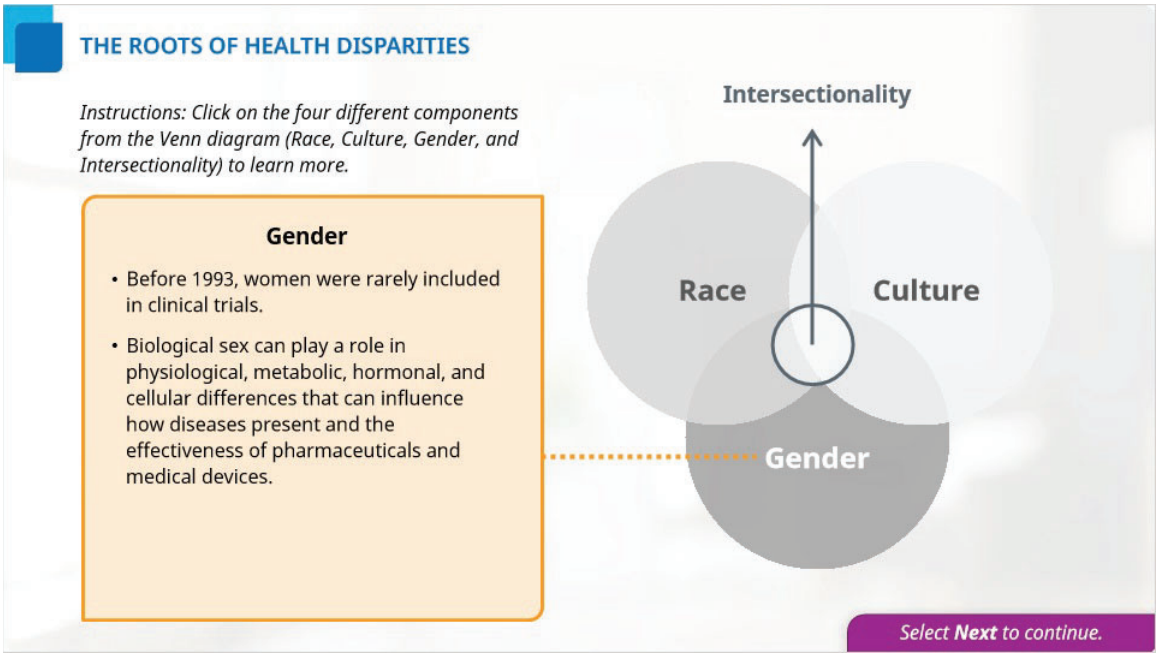
L2: Culture (Slide Layer)



Notes:

Culture: Underrepresentation of many marginalized communities among providers and staff resulted in cultural and linguistic barriers, implicit biases, and reduced access to culturally competent care for diverse patients.

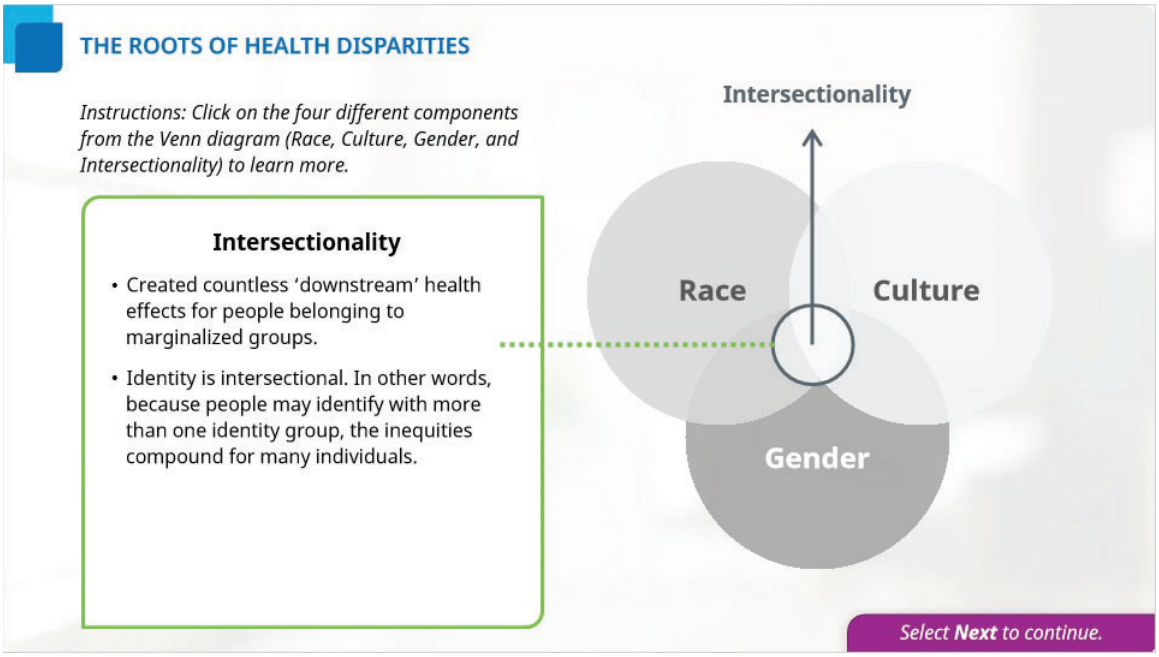
L3: Gender (Slide Layer)



Notes:

Gender: Before 1993, women were rarely included in clinical trials, even though biological sex can play a role in physiological, metabolic, hormonal, and even cellular differences that can influence how diseases present and the effectiveness of pharmaceuticals and medical devices.

L4: Intersectionality (Slide Layer)



Notes:

Intersectionality: These created countless 'downstream' health effects for people belonging to the marginalized groups. And because identity is intersectional; in other words, people may identify with more than one identity group, the inequities compound for many individuals.

5. Lesson 4

5.1 Lesson 4: Achieving Health Equity Together



Notes:

This takes us to our fourth and final lesson: Achieving Health Equity Together.

5.2 Organizational Health Equity Efforts



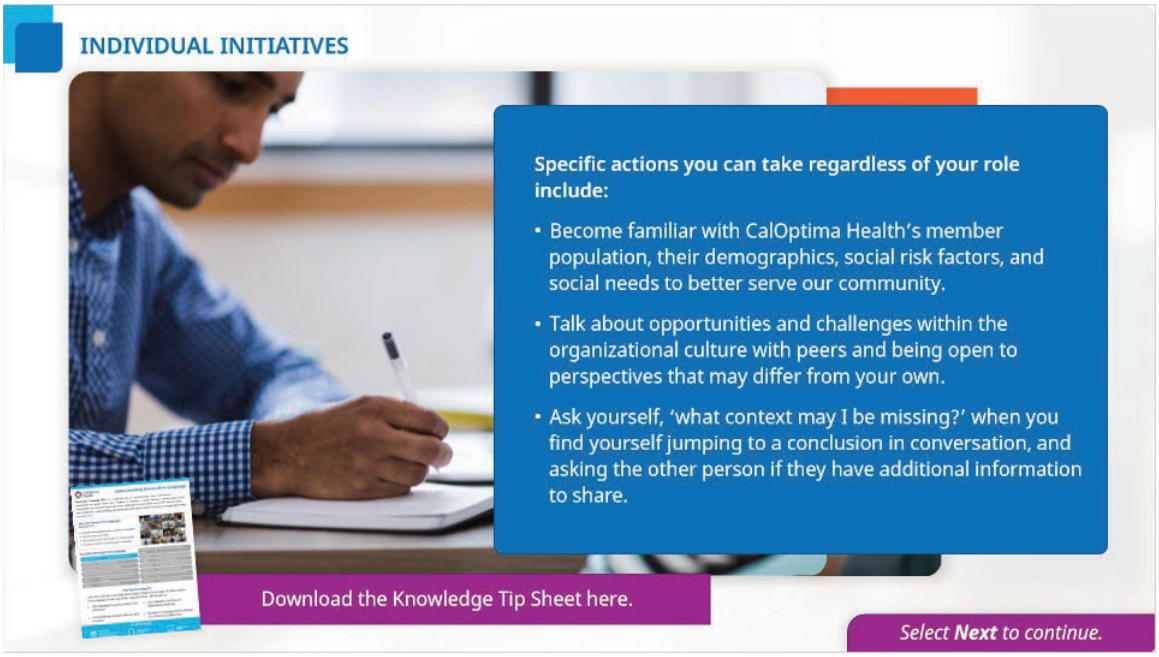
Notes:

Organizational Health Equity Efforts

Achieving health equity will require action and coordination at many levels. There is much that can be done at the organizational, community, and individual levels.

As an organization, CalOptima Health is committed to promoting health equity among its members, staff, providers, and within the communities where it operates. Best practices at the organizational level include evaluating current policies and procedures to ensure that they support health equity goals, collecting and disaggregating data to better understand the needs of current and potential membership, enhancing responsiveness to the cultural and linguistic needs of members, and collaborating with other health systems and community-based organizations to leverage shared efforts and make a stronger collective impact.

5.3 Individual Initiatives



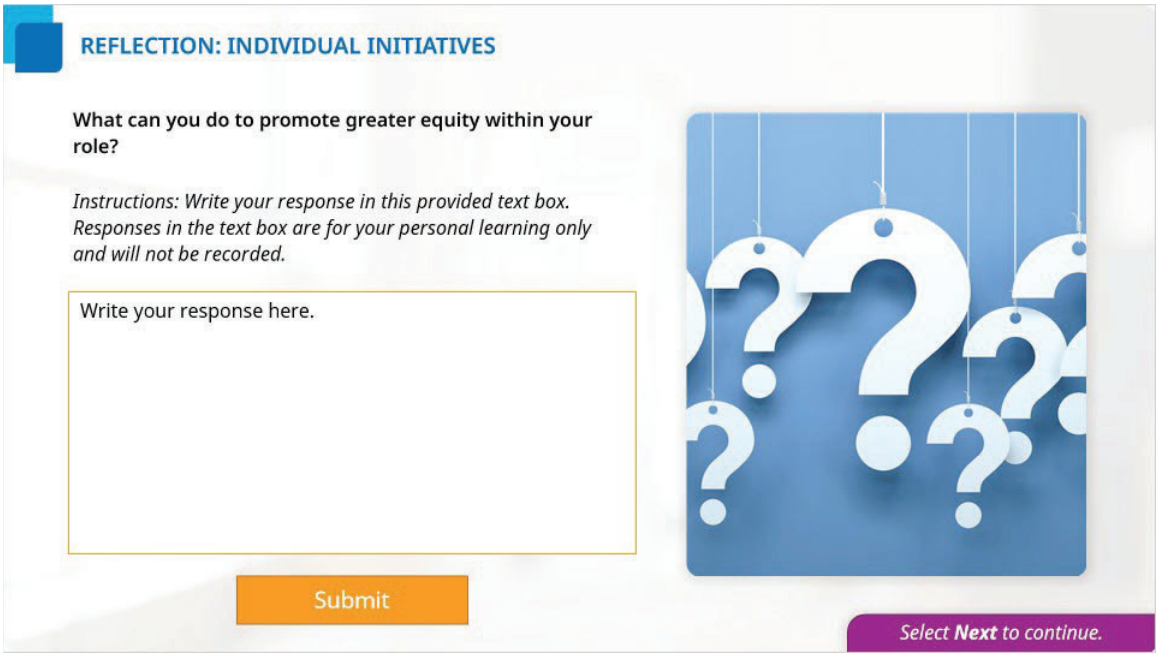
Notes:

Individual Initiatives

As you've now learned, health equity is fundamentally about fairness and dignity. And we all have the ability to strive for fairness and to treat others with dignity. Specific actions you can take regardless of your role include:

- Become familiar with CalOptima Health's member population, their demographics, social risk factors, and social needs to better serve our community.
- Talk about opportunities and challenges within the organizational culture with peers and being open to perspectives that may differ from your own.
- Ask yourself, 'what context may I be missing?' when you find yourself jumping to a conclusion in conversation, and asking the other person if they have additional information to share.

5.4 Reflection: Individual Initiatives

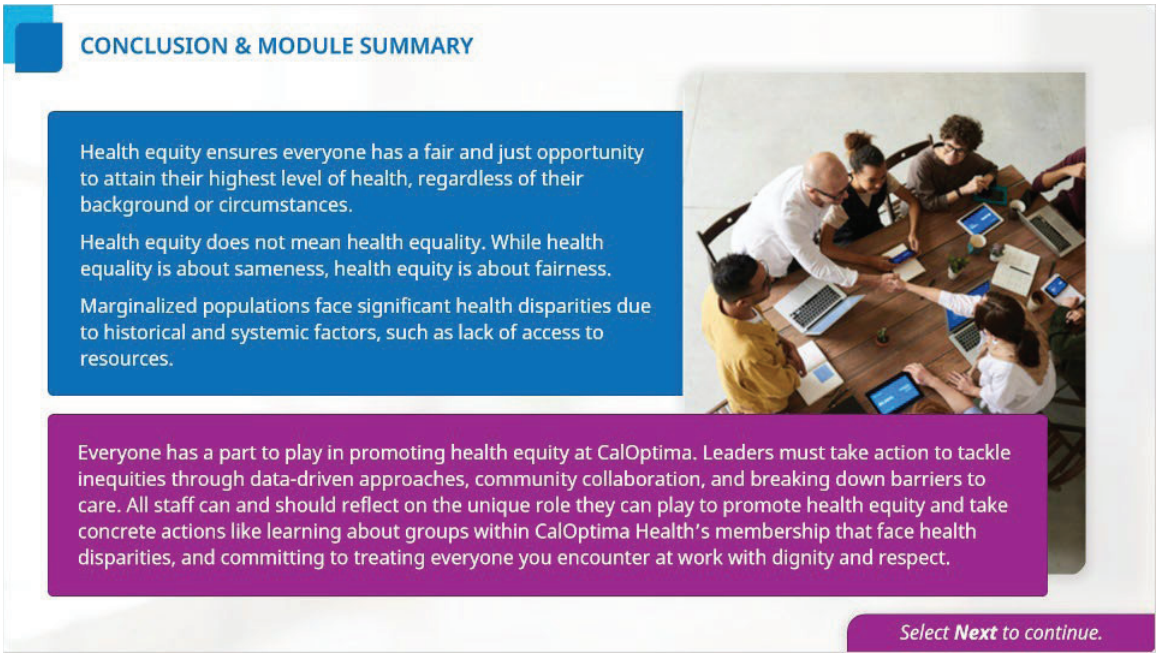


Notes:

Pause for a moment to reflect. Given what you have learned so far in this course, can you think of one thing you can do within your role to promote greater equity?

6. Conclusion

6.1 CONCLUSION & MODULE SUMMARY



Notes:

This brings us to the end of the material. Congratulations! As you return to your important roles at CalOptima Health, we hope you carry these key takeaways from the module

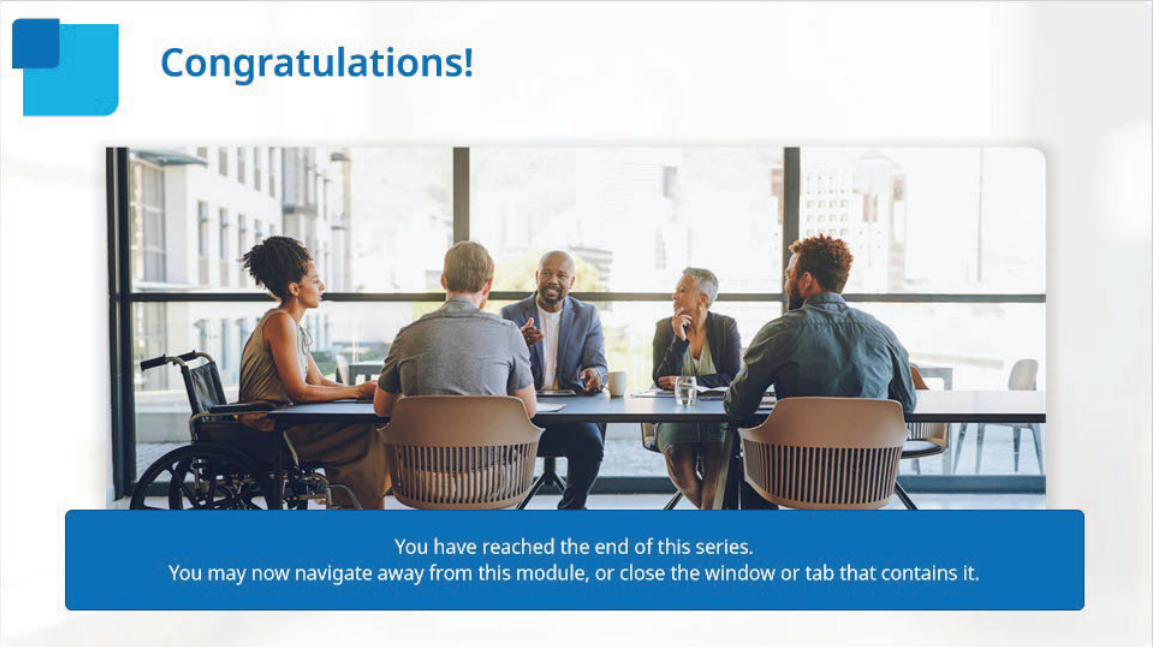
Health equity ensures everyone has a fair and just opportunity to attain their highest level of health, regardless of their background or circumstances

Health equity does not mean health equality. While health equality is about sameness, health equity is about fairness. It acknowledges that people have different levels of advantage and that we should individually and collectively work to reduce those gaps by addressing the unique barriers some groups face.

Marginalized populations face significant health disparities due to historical and systemic factors, such as lack of access to resources.

Everyone has a part to play in promoting health equity at CalOptima Health. Leaders must take action to tackle inequities through data-driven approaches, community collaboration, and breaking down barriers to care. All staff can and should reflect on the unique role they can play to promote health equity and take concrete actions like learning about groups within CalOptima Health's membership that face health disparities, and committing to treating everyone you encounter at work with dignity and respect.

7.4 Congratulations



Notes:

You have reached the end of this series.

You may now navigate away from this module, or close the window or tab that contains it.

Diversity, Equity, Inclusion, and Belonging

1. Introduction

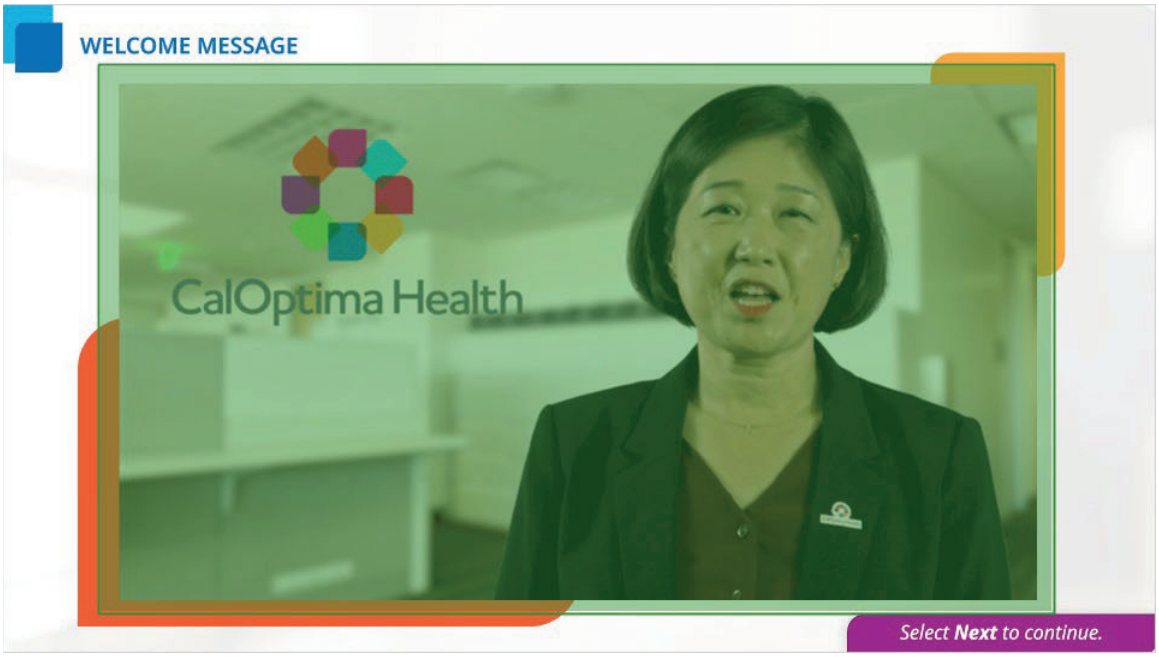
1.1 Welcome to Diversity, Equity, Inclusion, and Belonging (DEIB)



Notes:

Welcome to Diversity, Equity, Inclusion, and Belonging (DEIB), the second module in this three part training. To continue, click or tap NEXT, located in the bottom right of the media player.

1.3 Welcome Message



Notes:

Hello. My name is Yunkyung Kim, CalOptima Health's Chief Operating Officer. I am delighted to welcome you to our second module, Diversity, Equity, Inclusion and Belonging.

This module will focus on the importance of diversity, equity, inclusion and belonging and how an inclusive workplace benefits us all.
Research shows that diverse teams are:

- More innovative
- Make better decisions
- Drive stronger business results

Diverse and inclusive workplaces also have higher levels of employee engagement. This makes sense because we can all agree that it is more enjoyable to work somewhere that you feel accepted, respected and included.

CalOptima Health designed this second module to give you the basic knowledge as well as practical skills to begin your journey to becoming a Diversity, Equity, Inclusion and Belonging advocate.

I encourage you to approach this training with an open mind and a willingness to learn. Remember, the strength of our respective organizations lies in the diversity of our thoughts, experiences and perspectives. By enhancing our knowledge and skills in these areas, we are better equipped to create an inclusive workplace and deliver more equitable health outcomes for our members.

And with that, we welcome you to Diversity, Equity, Inclusion and Belonging!

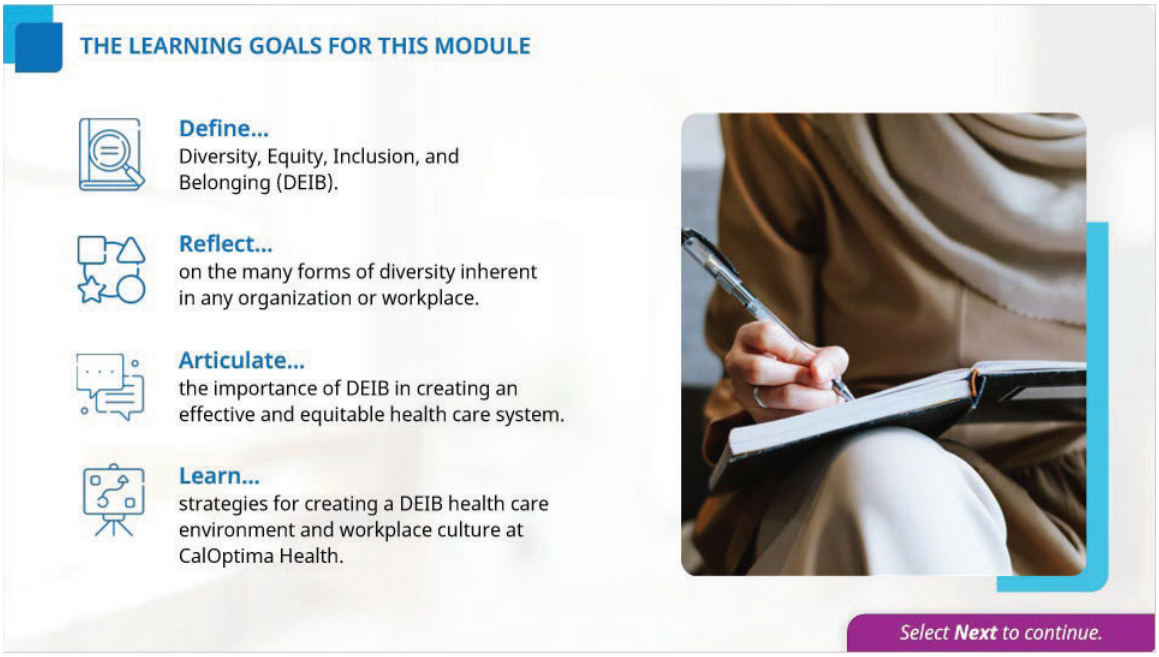
1.4 The Learning Roadmap for This Module



Notes:

In this module focused on health equity, we will cover four lessons:
Lesson 1: Understanding Diversity, Equity, Inclusion, and Belonging (DEIB)
Lesson 2: Applying Diversity and Equity to Health Care
Lesson 3: Making Inclusion and Belonging Actionable in Health Care
Lesson 4: Overcoming Challenges and Advancing DEIB at CalOptima Health

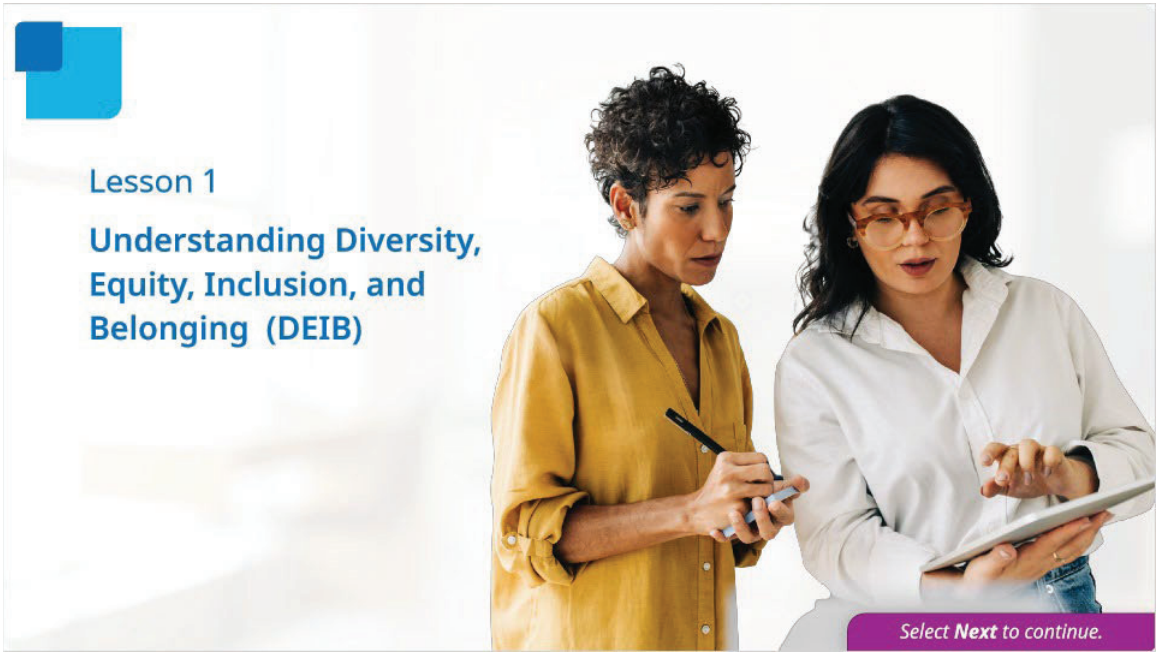
1.5 The Learning Goals for This Module



Notes:

By the end of the module, you should be able to:
1. Define Diversity, Equity, Inclusion, and Belonging (DEIB).
2. Reflect on the many forms of diversity inherent in any organization or workplace.
3. Articulate the importance of DEIB in creating an effective and equitable health care system.
4. Learn strategies for creating a DEIB healthcare environment and workplace culture at CalOptima Health.

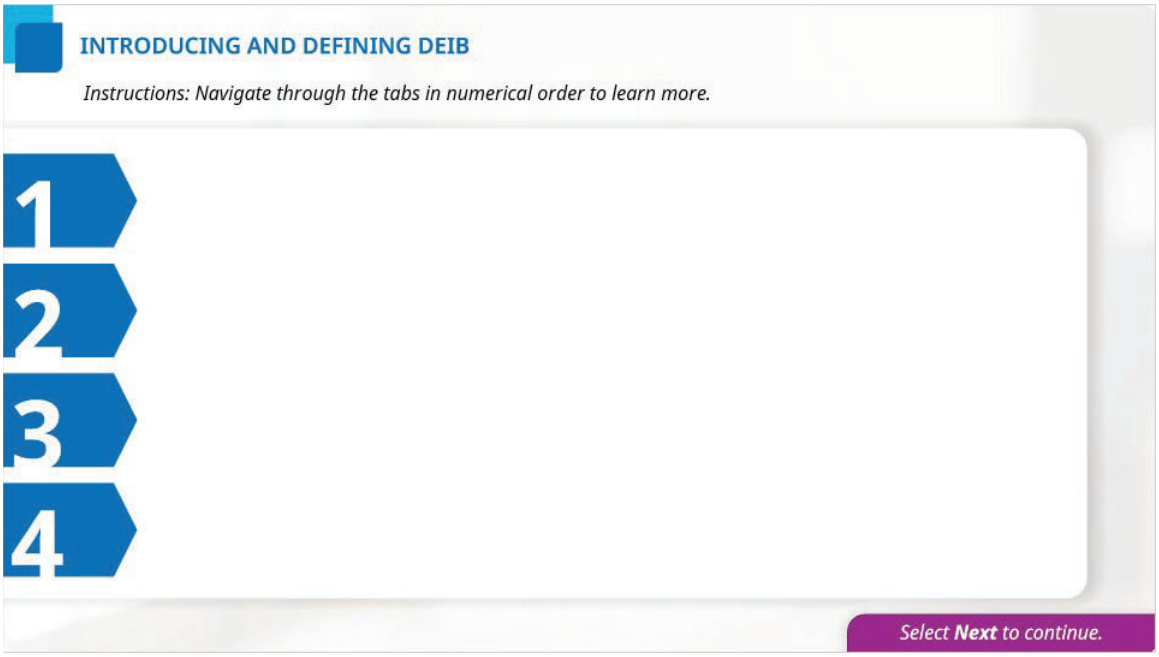
2.1 Lesson 1: Understanding Diversity, Equity, Inclusion, and Belonging (DEIB)



Notes:

Lesson 1: Understanding Diversity, Equity, Inclusion, and Belonging (DEIB)

2.2 Introducing and Defining DEIB

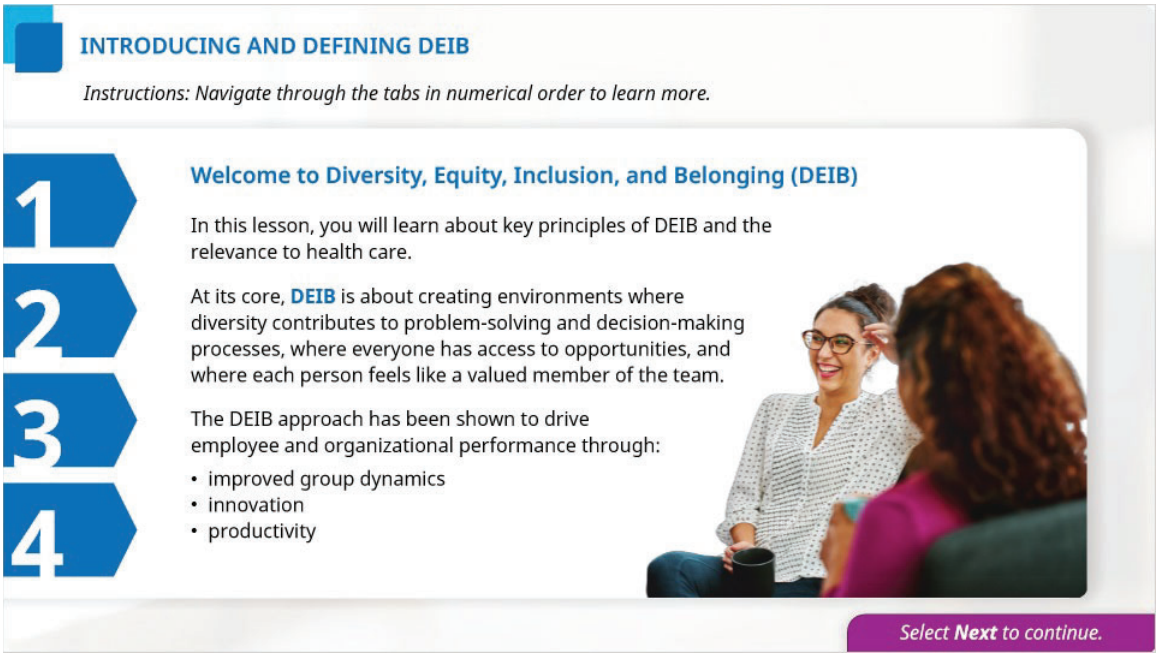


Notes:

Introducing and Defining Diversity, Equity, Inclusion, and Belonging (DEIB).

Navigate through the tabs in numerical order to learn more.

L1 (Slide Layer)



Notes:

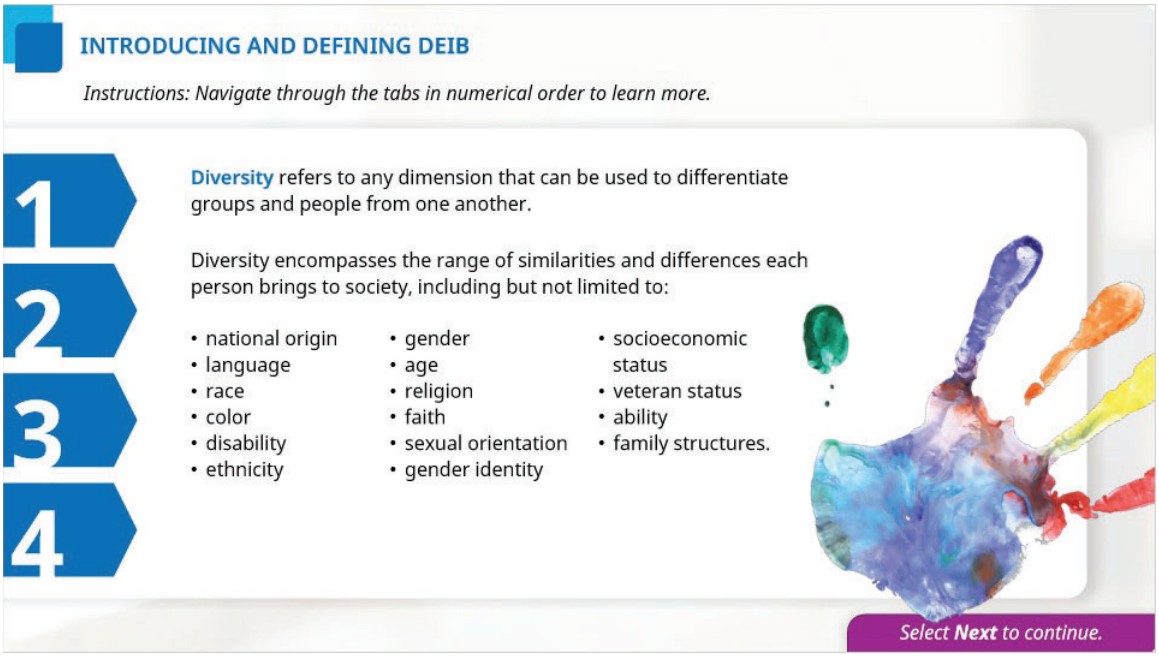
Welcome to the first of four lessons in this course on diversity, equity, inclusion, and belonging, also known as “DEIB.” In this lesson, you will learn about key principles of DEIB and the relevance to health care.

For many decades, organizational experts, CEOs, and employees have recognized the importance of diverse perspectives, inclusive teamwork, and a sense of belonging to foster effective collaboration and innovation.

At its core, DEIB is about creating environments where diversity contributes to problem-solving and decision-making processes, where everyone has access to opportunities, and where each person feels like a valued member of the team. The DEIB approach has been shown to drive employee and organizational performance through improved group dynamics, innovation and productivity. This approach not only enriches organizational culture but also drives health equity and ensures that our members receive excellent care.

Let’s start by defining the individual terms.

L2 (Slide Layer)

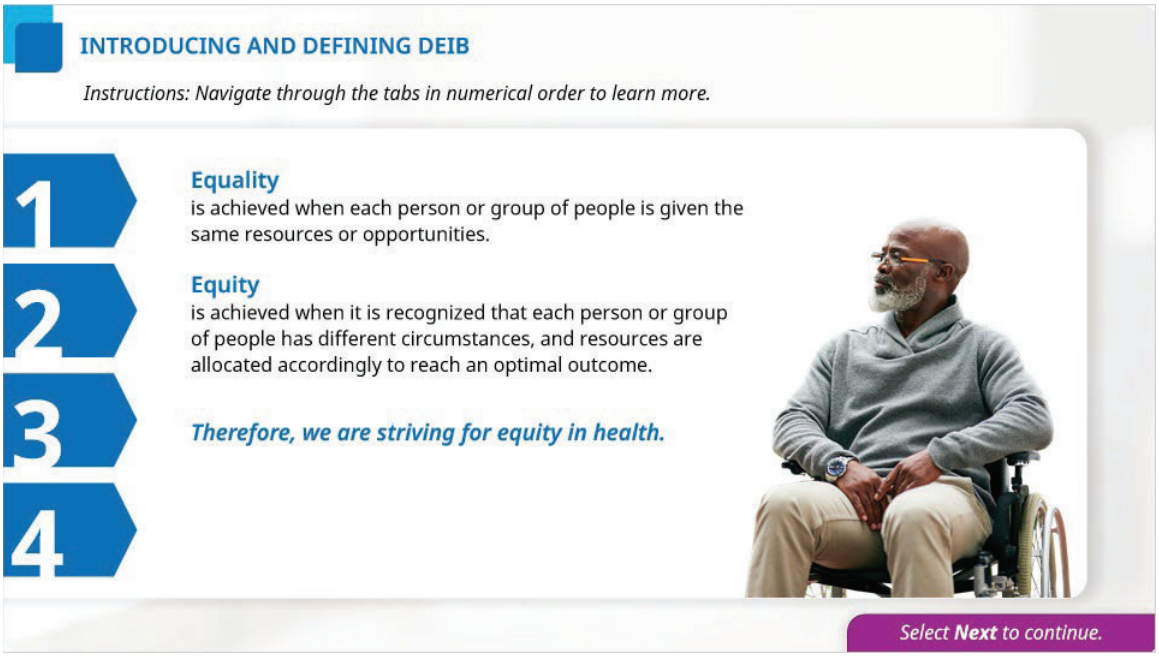


Notes:

Diversity refers to any dimension that can be used to differentiate groups and people from one another. Diversity encompasses the range of similarities and differences each person brings to society, including but not limited to national origin, language, race, color, disability, ethnicity, gender, age, religion, faith, sexual orientation, gender identity, socioeconomic status, veteran status, ability, and family structures. In many cases, a person’s identity may be intersectional, meaning that they identify with more than one identity group.

Here at CalOptima Health we have a workforce as diverse as our member population. CalOptima Health is an equal opportunity employer and makes all employment decisions on the basis of merit.

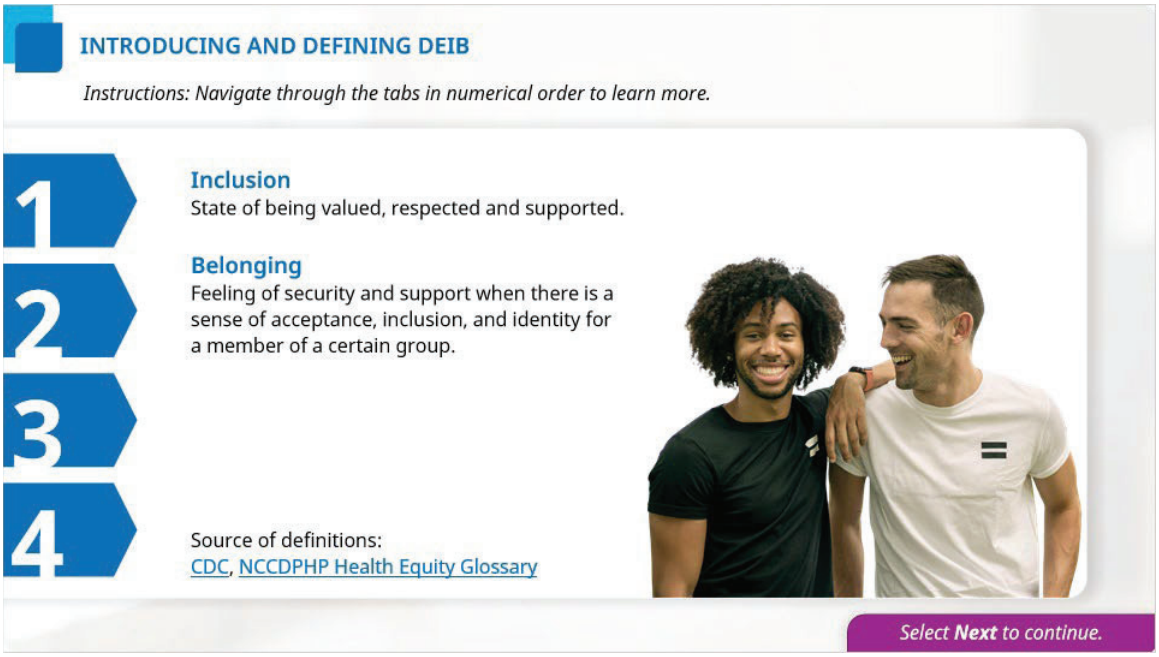
L3 (Slide Layer)



Notes:

Next, let's discuss the differences between Equality and Equity. Equality is achieved when each person or group of people is given the same resources or opportunities. Equity is achieved when it is recognized that each person or group of people has different circumstances, and resources are allocated accordingly to reach an optimal outcome. CalOptima Health is striving for organizational and health equity, which results in better and fairer outcomes for everyone.

L4 (Slide Layer)



Notes:

Inclusion is a state of being valued, respected and supported. It's about focusing on the needs of every individual and ensuring the right conditions are in place for each person to achieve his or her full potential.

Belonging is the feeling of security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group. It is when an individual can bring their authentic self wherever they go and still feel like they are needed and wanted.

3. Lesson 2

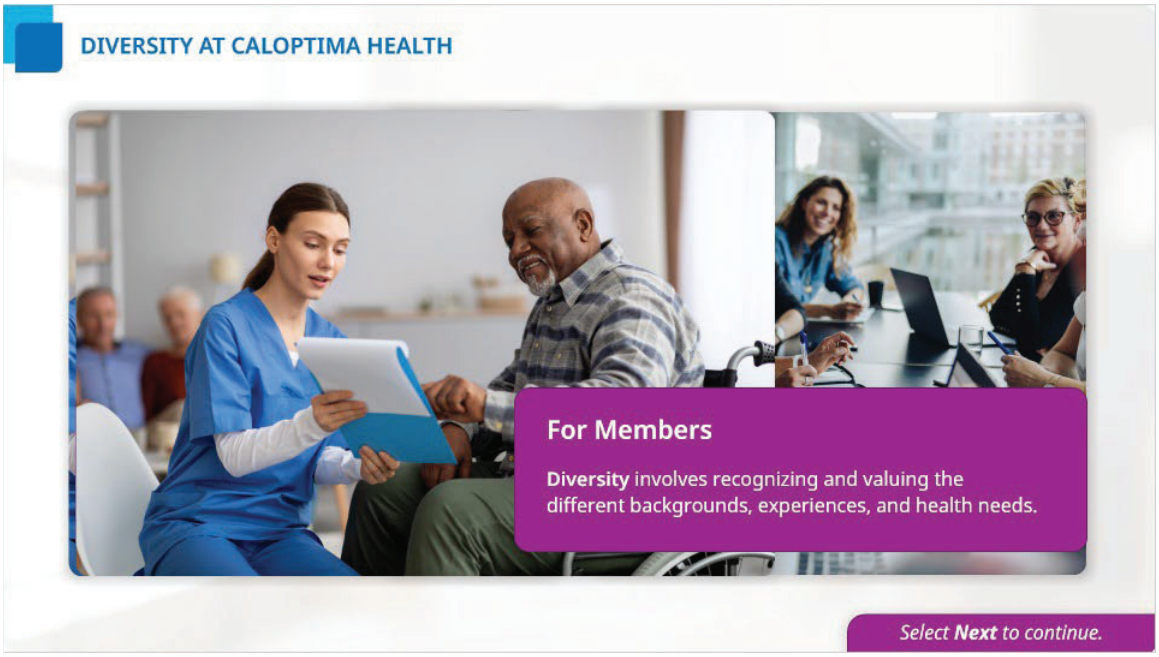
3.1 Lesson 2: Applying Diversity and Equity to Health care



Notes:

Lesson 2: Applying Diversity and Equity to Health care

3.2 Diversity at CalOptima Health



Notes:

Diversity at CalOptima Health

In this lesson, we'll spend time exploring each of the elements of DEIB in depth and what they look like in practice.

For CalOptima Health employees, diversity can mean having a team that reflects various cultural, demographic, and professional backgrounds, which can lead to more innovative solutions and a broader understanding of patient needs. Diverse teams are better equipped to provide culturally competent care and address health disparities effectively.

For members, diversity involves recognizing and valuing the different backgrounds, experiences, and health needs that individuals bring to the health care system. This includes understanding how various factors, such as language, beliefs, and life experiences, can influence their health and health care experiences.

3.3 Representation Positively Impacts Member Experience



Notes:

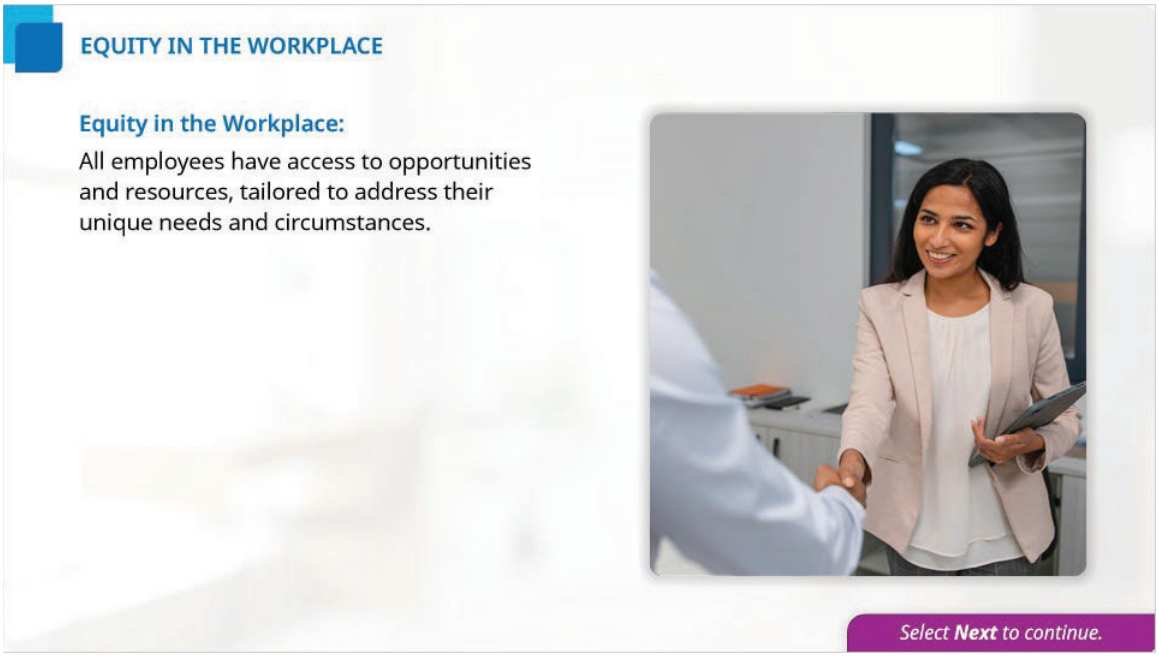
Representation Positively Impacts Member Experience

An important aspect of diversity among health care staff and providers is representation.

When members see providers who share or understand their cultural and personal backgrounds, it helps to build trust and improves communication. This is especially true for members from communities with a historical basis for mistrusting the medical profession.

Mistrust in the health care system among marginalized communities is often a result of a long history of discrimination, exploitation, and unequal treatment. Historical events, such as the Tuskegee Syphilis Study, where Black individuals were intentionally denied treatment to study the progression of syphilis, have left a legacy of suspicion and fear.

3.4 Equity in the Workplace



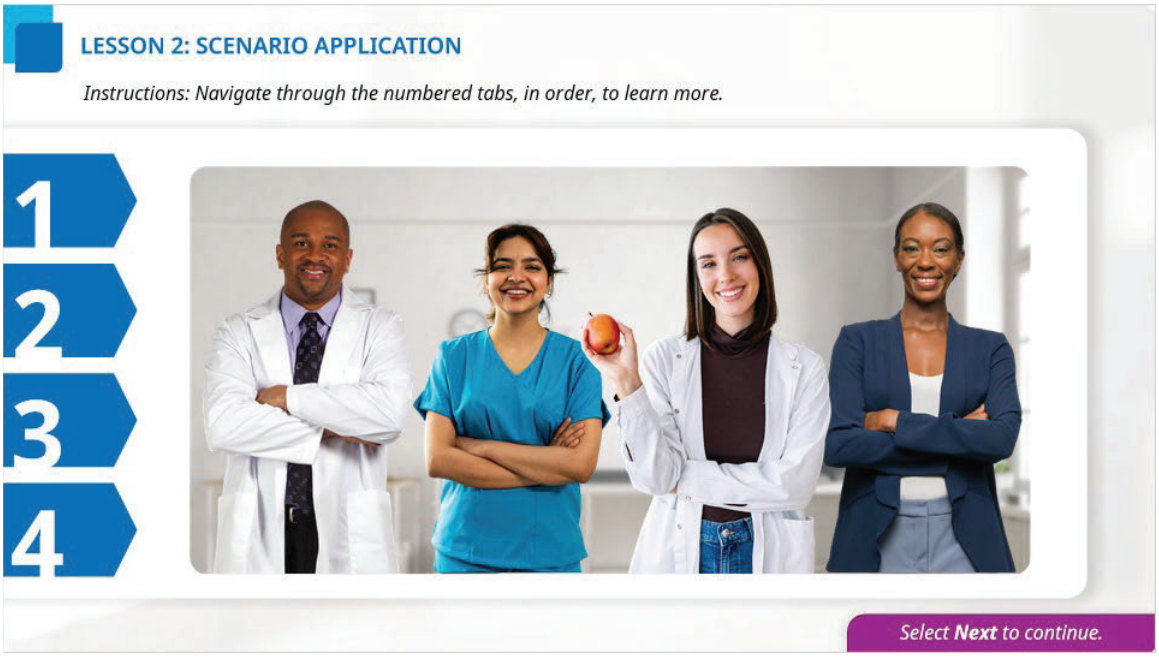
Notes:

Equity in the workplace involves creating an environment where all employees have access to opportunities and resources, tailored to address their unique needs and circumstances.

An example of an equitable workplace practice is allowing flexible scheduling for employees who have caregiving responsibilities or for religious employees to observe daily prayers or religious holidays.

By promoting equity, organizations can foster a more inclusive and supportive work environment, leading to improved job satisfaction, retention, and overall performance among health care professionals.

3.5 Lesson 2: Scenario Application



Notes:

Lesson 2: Scenario Application

The healthcare team at a community clinic is preparing to conduct a series of health workshops for a diverse group of members, including those with different cultural backgrounds, languages, and health literacy levels.

Navigate through the numbered tabs, in order, to learn more.

_____

The team includes:

- Dr. Jay: A family physician with expertise in chronic disease management.
- Nurse Patel: A bilingual nurse fluent in Spanish and English, with expertise in patient education.
- Tristan: A Registered Dietician familiar with dietary needs across cultures.
- Samantha: A social worker who specializes in community outreach and patient accessibility needs.

_____

The team prepares educational materials in multiple languages and ensures they are culturally relevant to their patient community. During the workshops, Dr. Jay explains the purpose of the health screenings using clear, non-technical language, and providing simple explanations of procedures and test results. Nurse Patel offers assistance to Spanish-speaking patients, translating medical information and answering questions in their preferred language. Tristan provides dietary advice that considers cultural food preferences. Samantha ensures that patients with disabilities or limited mobility have access to necessary resources and support, offering information in formats accessible to members with visual or hearing impairments, such as large print or sign language interpretation.

_____

Application question: How does the diversity within the healthcare team enhance their ability to provide inclusive and effective care? Examples include language skills, cultural awareness, and expertise. What are specific examples that illustrate how the team's diverse skills and perspectives contribute to better patient outcomes?

_____

Answer feedback:

Your answer may have included any of the following:

- Diversity within the health care team enhances the ability to provide inclusive and effective care.
- Team members who are bilingual, like Nurse Patel, can communicate with Spanish speaking patients.
- Patients can receive clear, accurate information, such as instructions or treatment plans, in their preferred language.
- Team members, such as Tristan, can provide treatment plans and advice that considers cultural food preferences.
- A team member, such as Samantha, who specializes in accommodations and accessibility, can provide resources and support to patients with physical impairments.

4. Lesson 3

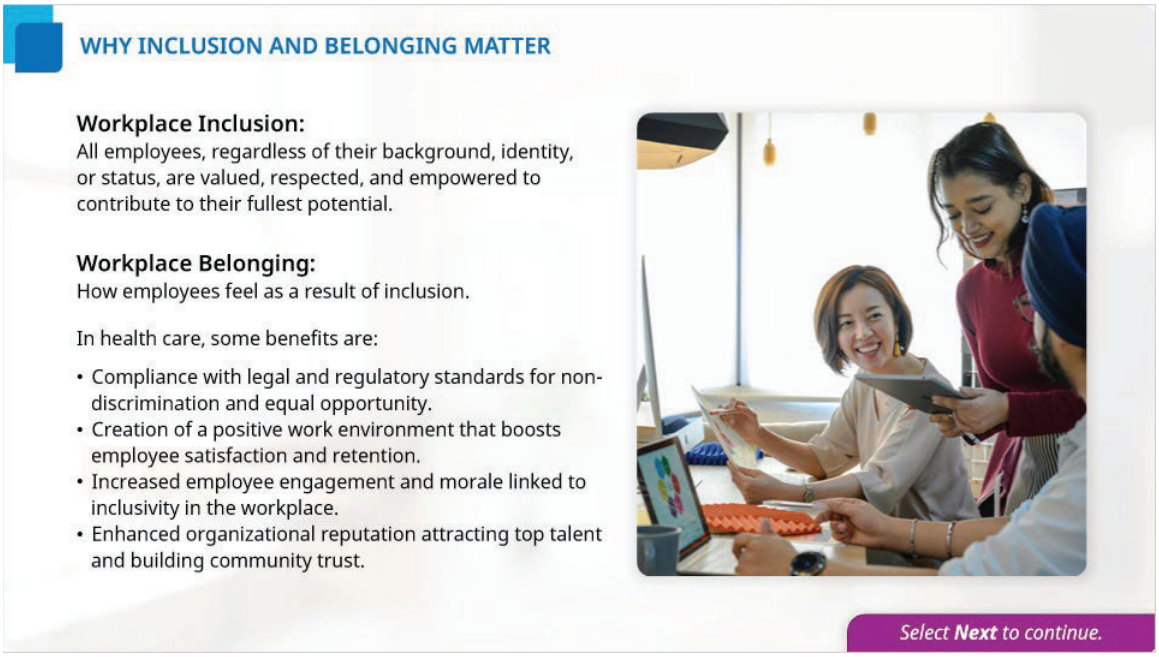
4.1 Lesson 3: Making Inclusion and Belonging Actionable



Notes:

Lesson 3: Making Inclusion and Belonging Actionable

4.2 Why Inclusion and Belonging Matter



Notes:

Why Inclusion and Belonging Matter

Workplace inclusion refers to the practice of creating an environment where all employees, regardless of their background, identity, or status, are valued, respected, and empowered to contribute to their fullest potential. Belonging is how employees feel as a result.

In health care, some benefits of practicing inclusion and belonging are:

- Assisting organizations to comply with legal and regulatory standards related to non-discrimination and equal opportunity.
- Fostering a positive work environment, which enhances employee satisfaction and reduces turnover. The Centers for Disease Control and Prevention (CDC) reports that inclusive workplaces have higher levels of employee engagement and morale. Employees who feel included are more likely to stay with their organization, reducing recruitment and training costs.

Thriving from a stronger reputation, which can attract top talent and foster trust among patients and the community.

5. Lesson 4

5.1 Lesson 4: Overcoming Challenges and Advancing DEIB at CalOptima Health



Notes:

Lesson 4: Overcoming Challenges and Advancing DEIB at CalOptima Health

5.2 Challenges to DEIB at Work



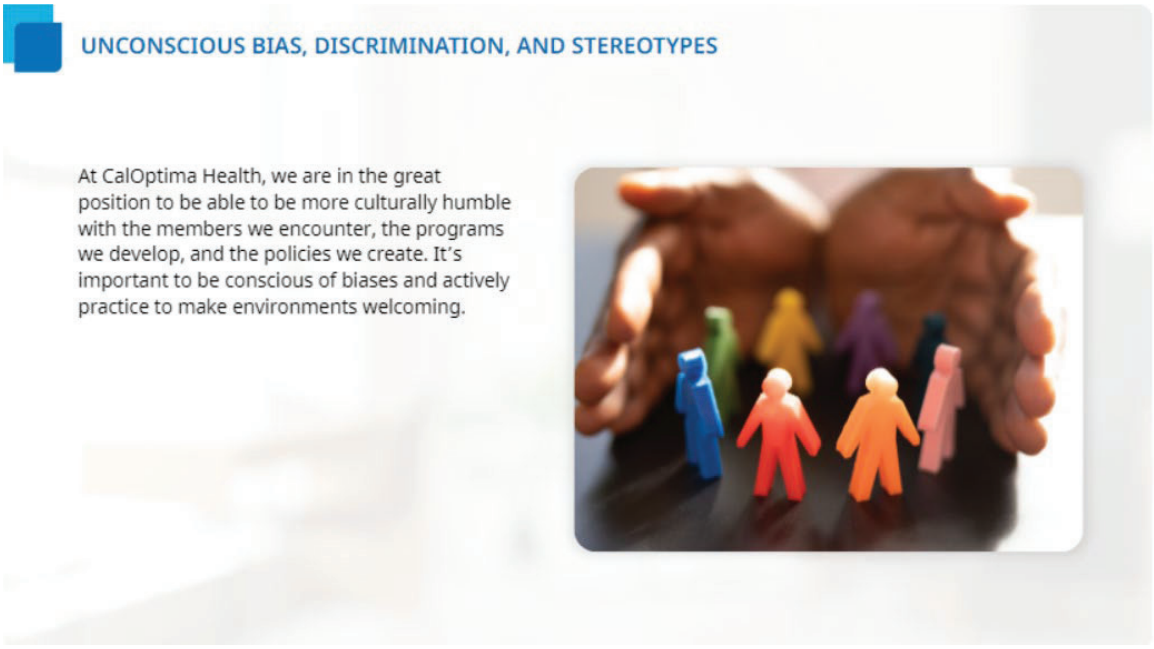
Notes:

Challenges to DEIB at Work

Although there are many organizational, financial, and personal benefits to DEIB at work, some workplaces struggle to successfully integrate DEIB in their culture and operations.

In this lesson, we will explore key obstacles that can impede our efforts to create health care organizations that support DEIB. Understanding these barriers is crucial for developing strategies to overcome them and approaches we can individually and collectively take to overcome challenges and foster DEIB at CalOptima Health.

5.3 Unconscious Bias, Discrimination, and Stereotypes



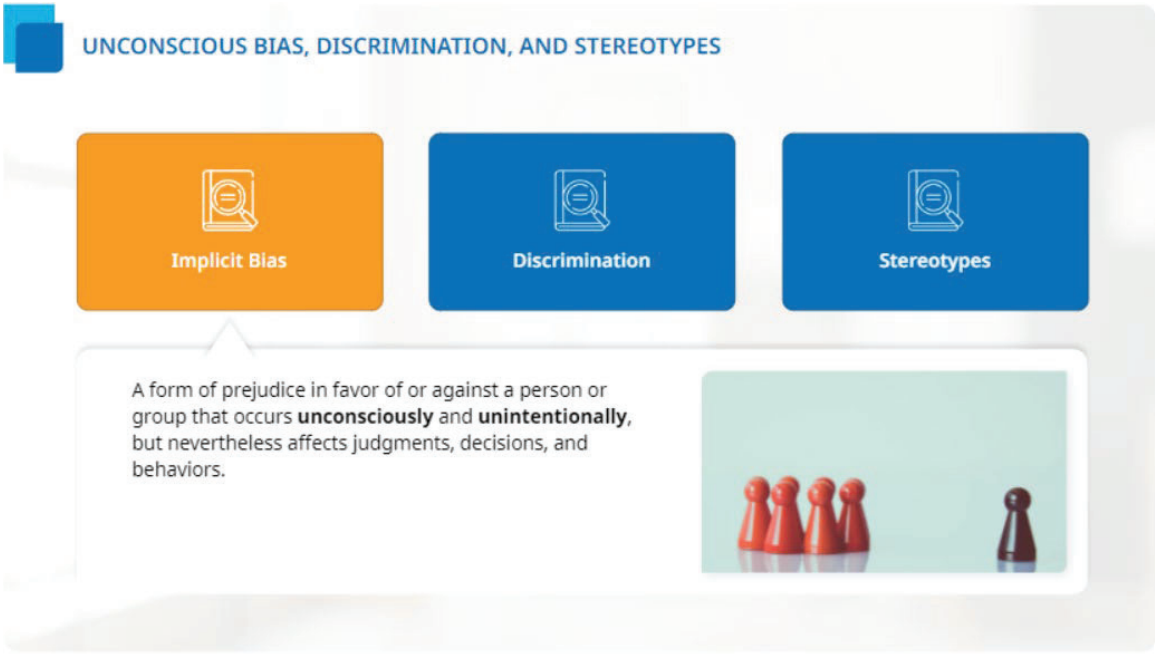
Notes:

Unconscious Bias, Discrimination, and Stereotypes

At CalOptima Health, we are in the great position to be able to be more culturally humble with the members we encounter, the programs we develop, and the policies we create. It's important to be conscious of biases and actively practice to make environments welcoming.

Let's explore the following terms to understand the impact of bias. One note is these terms are ever-changing and evolving in the field of DEIB. For the sake of this training, we are drawing from the CDC's definition of bias.

Implicit bias (Slide Layer)



Notes:

The CDC states that implicit bias is a form of prejudice in favor of or against a person or group that occurs unconsciously and unintentionally, but nevertheless affects judgments, decisions, and behaviors. These types of bias can include race and ethnicity bias, age bias, faith or religion bias, gender bias, LGBTQIA+ community bias, and ability bias.

To mitigate unconscious and implicit bias, we can engage in self-reflection, seek feedback, and participate in bias training programs. Awareness is the first step towards reducing the impact of these biases in our workplace.

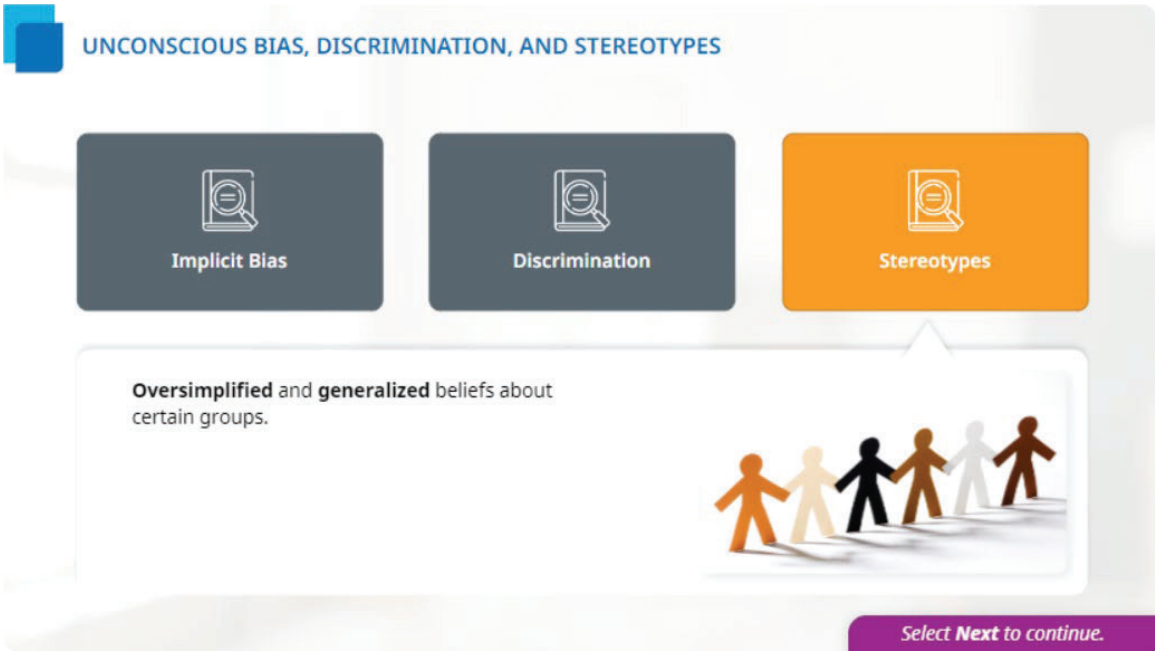
Discrimination (Slide Layer)



Notes:

Discrimination involves treating people unfairly based on characteristics such as race, gender, ethnicity, faith, or ability which can lead to inequitable opportunities for career advancement and professional development. When discrimination is present, it undermines trust and morale among employees, making it challenging to build a cohesive and supportive team.

Stereotypes (Slide Layer)



Notes:

Stereotypes-oversimplified and generalized beliefs about certain groups-can affect how employees are perceived and treated. These biases can lead to miscommunication, reduced collaboration, and missed opportunities for diverse perspectives to contribute to problem-solving and innovation.

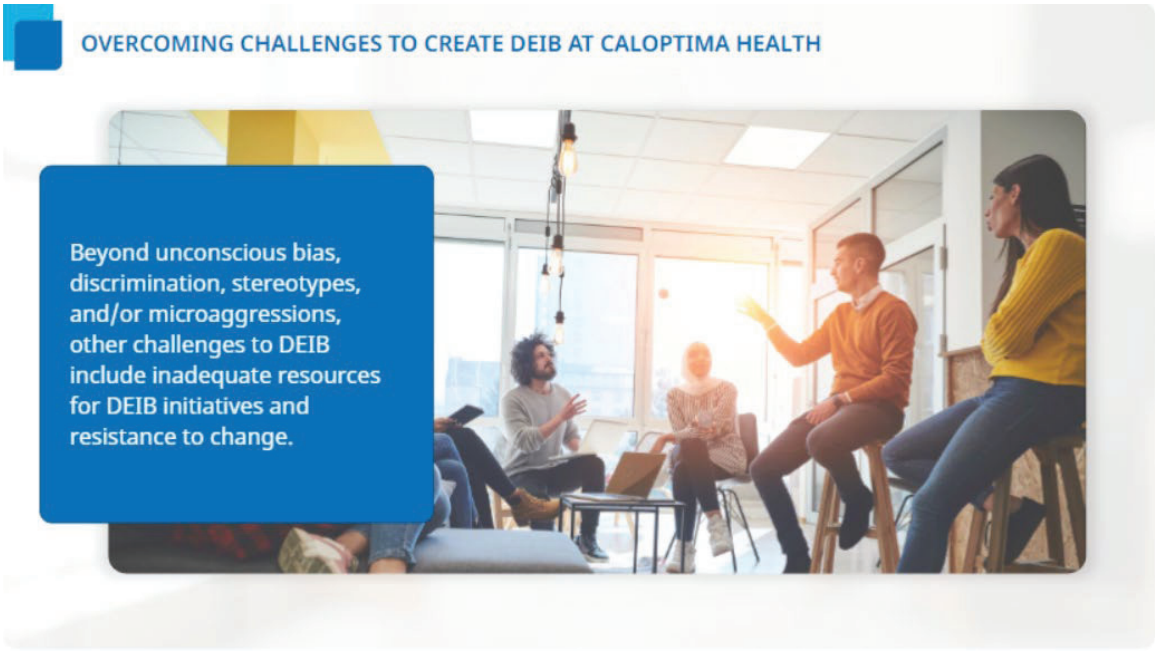
5.4 Microaggressions



Notes:

Microaggressions are brief, everyday interactions or behaviors that, intentionally or unintentionally, convey derogatory or negative slights or insults toward individuals from marginalized groups. These can be unintentional and may seem minor, but they accumulate and contribute to a hostile environment. Examples include comments like, "You speak English so well" or assumptions about someone's role based on their appearance. To address microaggressions, we need to educate ourselves and others, encourage open dialogue, and support those who experience them. Creating awareness and promoting respect are key steps in reducing their occurrence.

5.5 Overcoming Challenges to Create DEIB at CalOptima Health



Notes:

Overcoming Challenges to Create DEIB at CalOptima Health

Beyond unconscious bias, discrimination, stereotypes, and/or microaggressions, other challenges to DEIB include inadequate resources for DEIB initiatives and resistance to change. Addressing these challenges requires a multifaceted approach. This includes ongoing education, transparent communication, and a commitment to DEIB from all organizational levels.

Leaders must champion DEIB efforts, allocate necessary resources, and create accountability measures. By recognizing and addressing these challenges, we can move towards a more inclusive, equitable, and supportive workplace for all.

On an individual level, we can all become more aware of these challenges and what we can do to help prevent the occurrence of social biases and discriminatory practices.

From the following actions, which resonate with you or which ones you would like to start incorporating into your workplace habits? There may be some you already use that you can recommend to others.

- Read books, articles, or watch videos on DEIB topics.
- Listen actively to understand others' viewpoints.
- Include everyone in team discussions.
- Respect and promote team diversity.
- Use inclusive language and avoid assumptions about people.
- Step in politely if you see someone being disrespectful.
- Stay updated on best practices for diversity and inclusion.
- Practice self-reflection.
- Be patient with yourself and others; change takes time.

6. Conclusion

6.1 Conclusion & Summary



Notes:

Conclusion & Summary

Recognize and value diversity among individuals and groups, including identity, culture, beliefs, and experiences. In health care organizations, this can mean valuing a team with diverse cultural, demographic, and professional backgrounds and perspectives. With members, this means recognizing and valuing different backgrounds, experiences, and health needs.

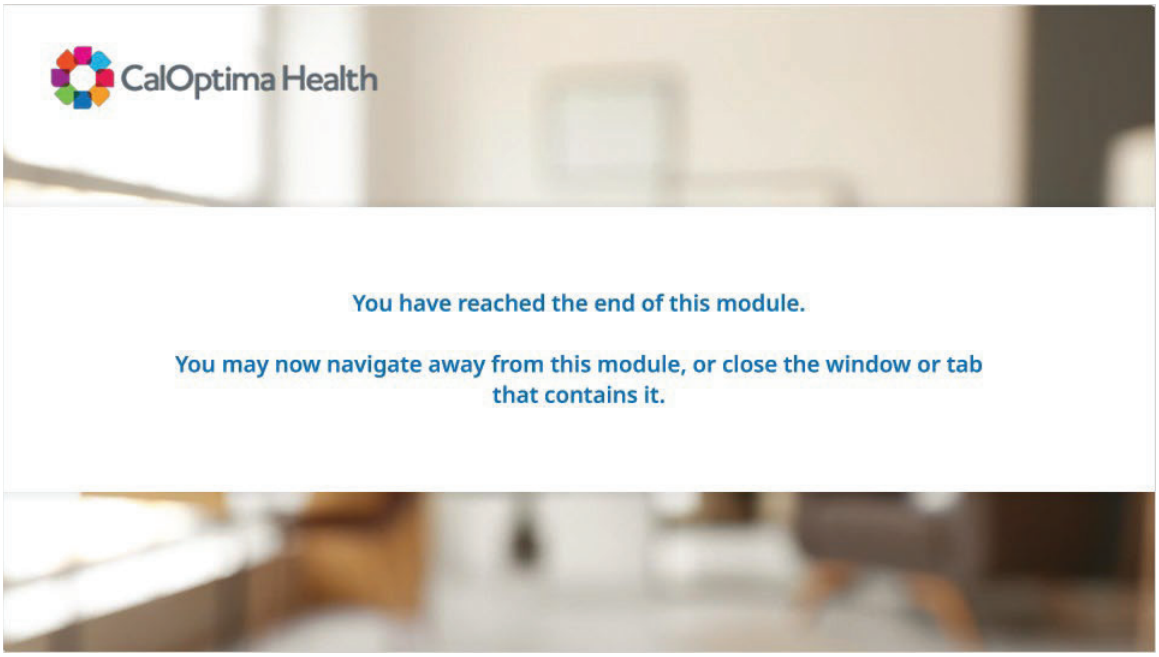
Equity is the fair access to resources and opportunities for all and is tailored to meet unique needs, including the norms, practices, and policies that ensure fair opportunities and workplace outcomes.

Inclusion refers to the degree to which organizations welcome all employees and enable them to contribute meaningfully. Practicing inclusive behaviors and communication fosters a positive workplace, enhances employee satisfaction and retention, and improves the member experience.

Belonging is how the workforce experiences the workplace and whether they perceive they have the support and resources to thrive. Inclusion and belonging lead to higher employee engagement, morale, and reduced turnover, benefiting both the organization and the community.

When all of these dynamics are at play at once, a more well-rounded community in Health care and beyond can be realized. We appreciate you doing your part in making this diverse, equitable, inclusive community where everyone belongs - a reality.

6.2 End of Course



Notes:

You have reached the end of this module. You may now navigate away from this module, or close the window or tab that contains it.

Cultural Competency: The Foundation of Equitable Health Care

1. Introduction

1.1 Welcome to Cultural Competency

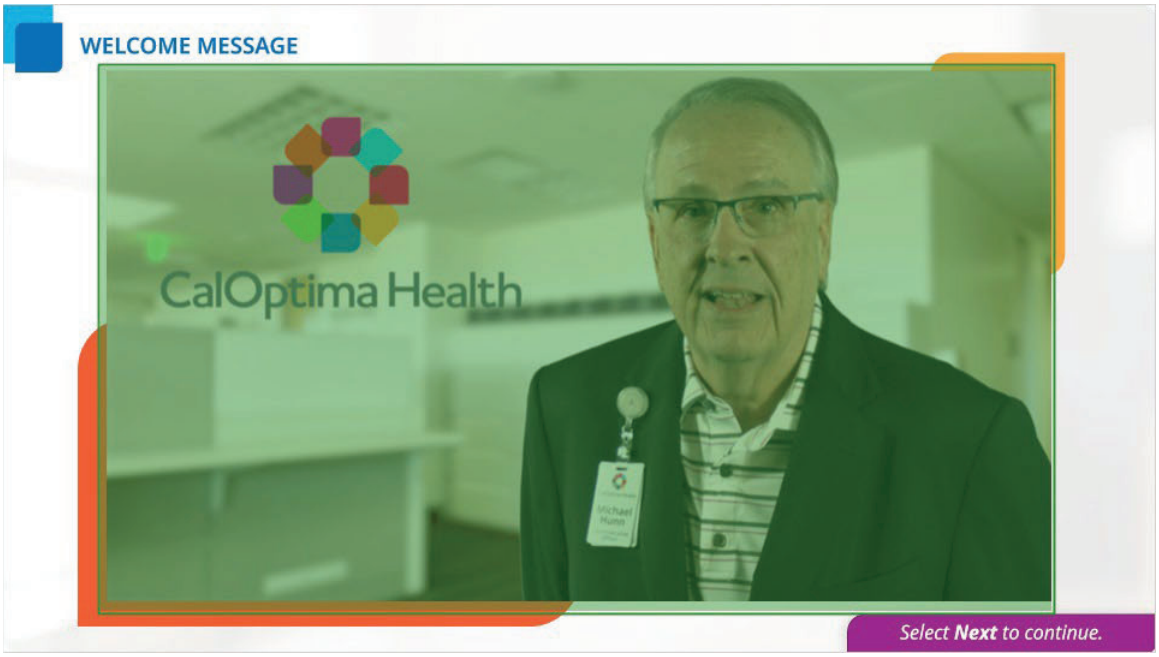


Notes:

Welcome to Cultural Competency: The Foundation of Equitable Health Care, provided by CalOptima Health.

Please select next, located in the bottom right of this media player, to continue.

1.3 Welcome Message



Notes:

Hello. My name is Michael Hunn, CalOptima Health's Chief Executive Officer. I am excited to introduce our Diversity, Equity, Inclusion and Belonging training series. This effort represents a significant step forward in our commitment to fostering an environment that embraces and celebrates diversity in all of its forms.

As Orange County's single largest health insurer, CalOptima Health serves nearly 1 in 3 residents, and our members are very diverse in terms of their backgrounds, ethnicities, cultures and languages.

This training provides an opportunity for all of us to learn and grow together and, ultimately, improve the quality of care for our Members. We have designed each module to provide information that will help you do your job even more effectively.

This training is more than just a series of modules - it's the first step on a learning journey that will positively impact how CalOptima Health staff and our providers work together to care for the diverse communities we serve. By enhancing our knowledge and skills in these areas, we are better equipped to create inclusive workplaces and deliver more equitable health outcomes for our members.

The first module in this training focuses on Cultural Competency and is designed to expand how we define identity and culture.
Your active participation in this program is not just welcome but essential. Together, we have the power to create positive change, both within our organizations and in the lives of those we serve. I look forward to embarking on this important journey with all of you.

And with that, welcome to Cultural Competency!

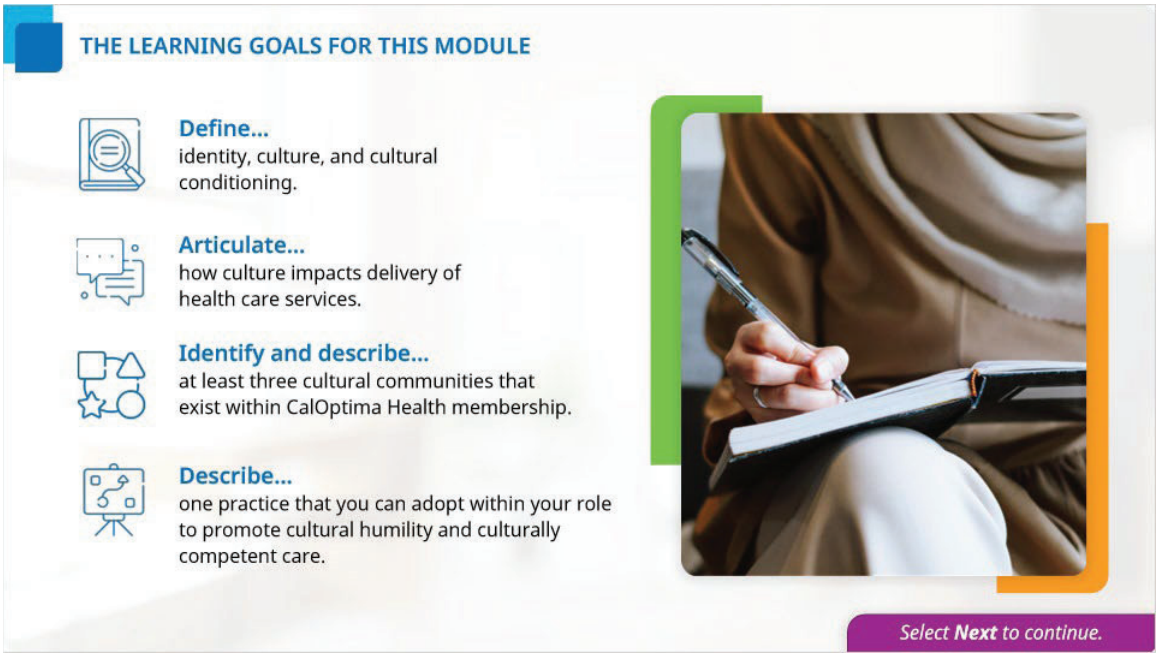
1.4 The Learning Roadmap for This Module



Notes:

In this course focused on cultural competency, we will cover four lessons:
1. Lesson 1: Introduction to Identity and Culture
2. Lesson 2: Cultural Communities within the CalOptima Health Membership
3. Lesson 3: Cultural Humility and Member Engagement
4. Lesson 4: Linguistic Competence and Available Language Services

1.5 The Learning Goals for This Module



Notes:

By the end of the course, you should be able to:
1. Define identity, culture, and cultural conditioning.
2. Articulate how culture impacts delivery of health care services.
3. Identify and describe at least three cultural communities that exist within CalOptima Health membership.
4. Describe one practice that you can adopt within your role to promote cultural humility and culturally competent care.

2. Lesson 1

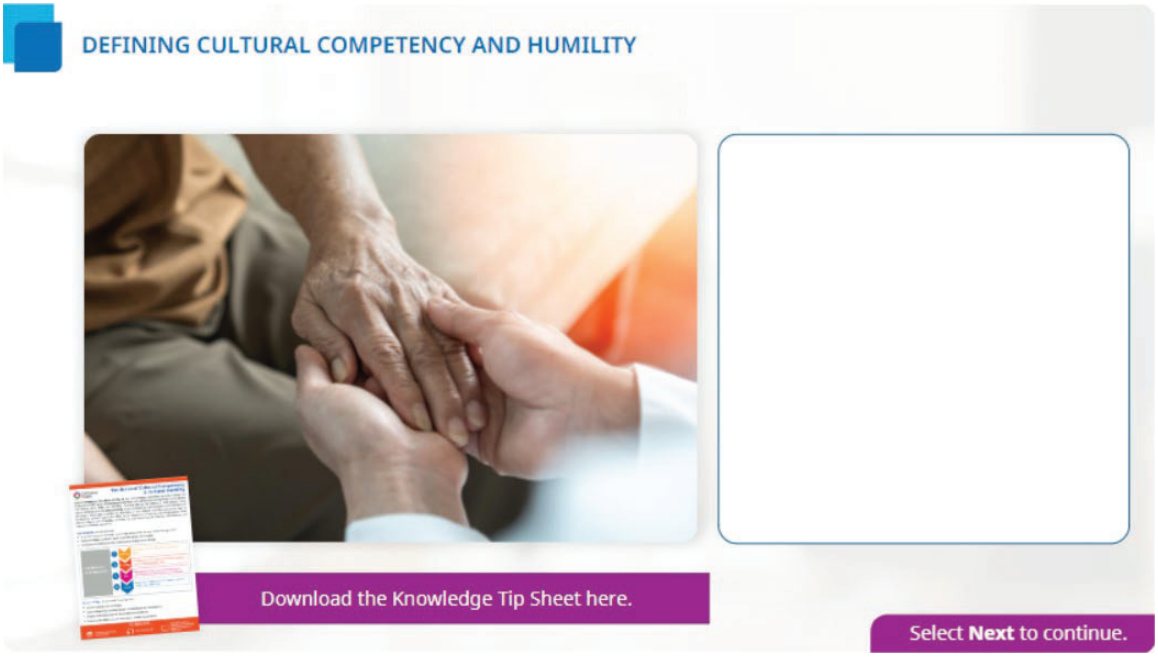
2.1 Lesson 1: Understanding Diversity, Equity, Inclusion, and Belonging (DEIB)



Notes:

Lesson 1: Introduction to Identity and Culture

2.2 Defining Cultural Competency and Humility



Notes:

Cultural competency in health care means that healthcare professionals recognize and integrate members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into services provided.

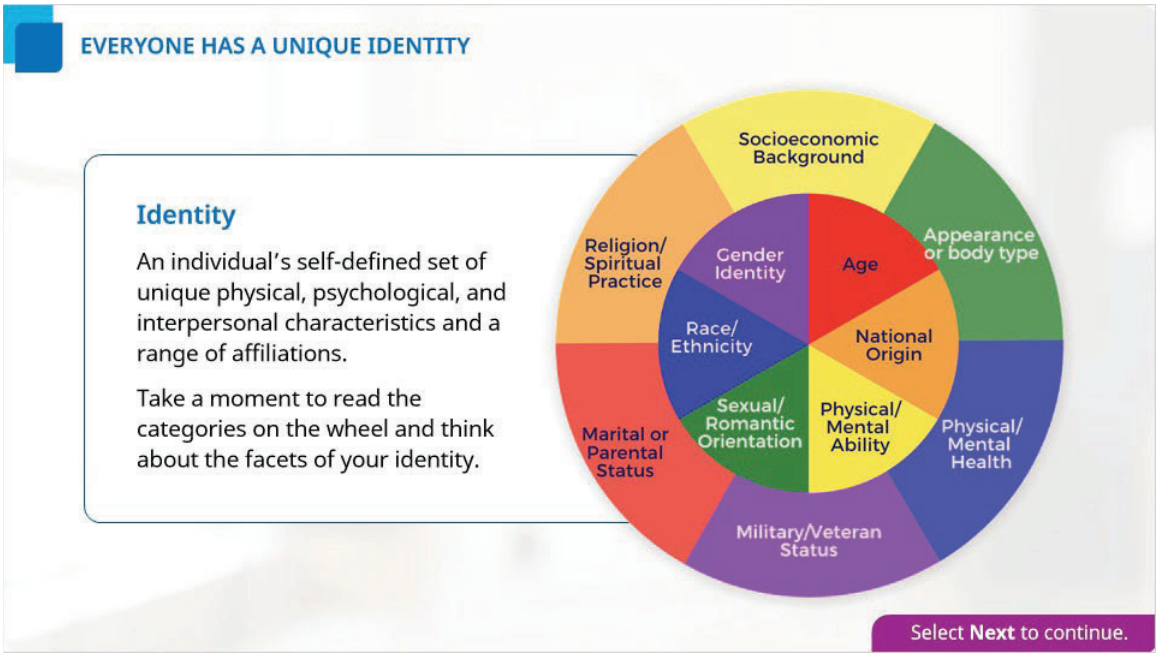
CalOptima Health strives to be a culturally competent system, which means that our staff and contracted partners:
- acknowledge the importance of identity and culture,
- recognize the potential impact of cultural differences on health care practices,
- expand our cultural knowledge, and
- adapt services to meet culturally unique needs.

This module also addresses what it means to personally lead with cultural humility. Cultural humility means acknowledging that one does not know everything about another person's lived experience. The demonstration of cultural humility includes a willingness to learn from others about the experiences that have shaped their identity. While competence suggests mastery, humility refers to an intrapersonal and interpersonal open and reflective mindset that cultivates a desire to understand and appreciate another person. Demonstrating cultural humility is critical for person-centered care.

An individual leading with cultural humility within the system has the ability to:
- reflect on their own identity and culture,
- value and respect different identities and cultures, and
- understand and adapt to the dynamics inherent when cultures interact.

Cultural competency and humility are central to CalOptima Health's mission, which is 'to serve Member health with excellence and dignity, respecting the value and needs of each person.'

2.3 Everyone Has a Unique Identity



Notes:

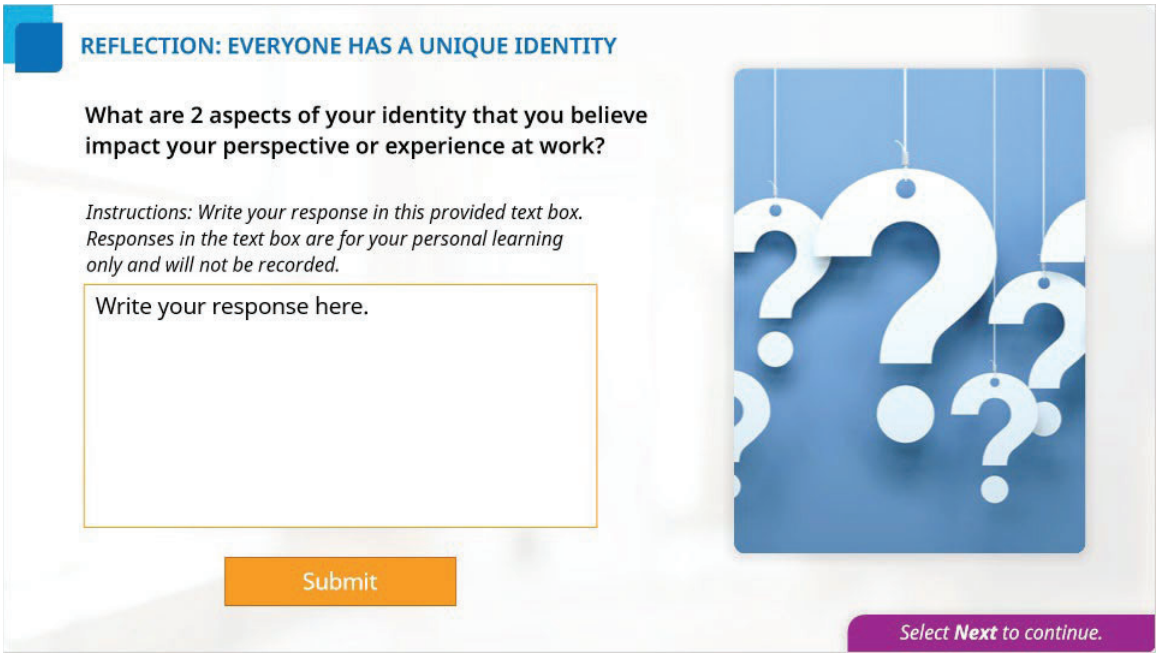
At its core, culture is about identity.

Identity is an individual's self-defined set of physical, psychological, and interpersonal characteristics and a range of experiences and affiliations. Identity isn't singular. There are many aspects that make you, you.

Some parts of your identity may relate to your physical body, where you are from, or traits passed down from your parents. Other parts may be about how you see the world, what you value, the religion you follow, or what you have experienced. Some traits may be with you from birth until death, whereas others may change or evolve during your lifetime.

This wheel shows many aspects that comprise identity, and it still doesn't capture all of the possibilities. Your values, memories, and interests are also identity traits. Take a moment to read the categories on the wheel and think about the facets of your identity.

2.4 Reflection: Everyone Has a Unique Identity

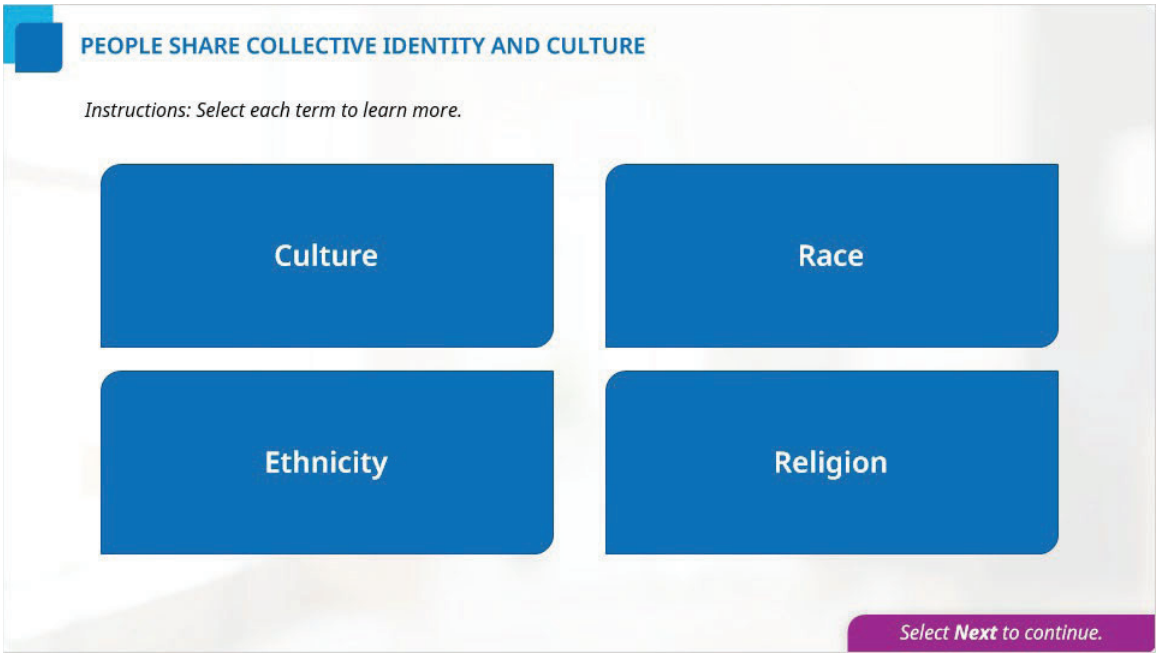


Notes:

Reflection: What are 2 aspects of your identity that you believe impact your perspective or experience at work?

Write your response in this provided text box. Responses in the text box are for your personal learning only and will not be recorded.

2.5 People Share Collective Identity and Culture



Notes:

While everyone has a unique identity, parts of identity are shared with others and are based on common associations and experiences. We call these shared patterns of thinking, feeling, and acting acquired from common social environments and experiences culture.

Select each to learn more.

_____

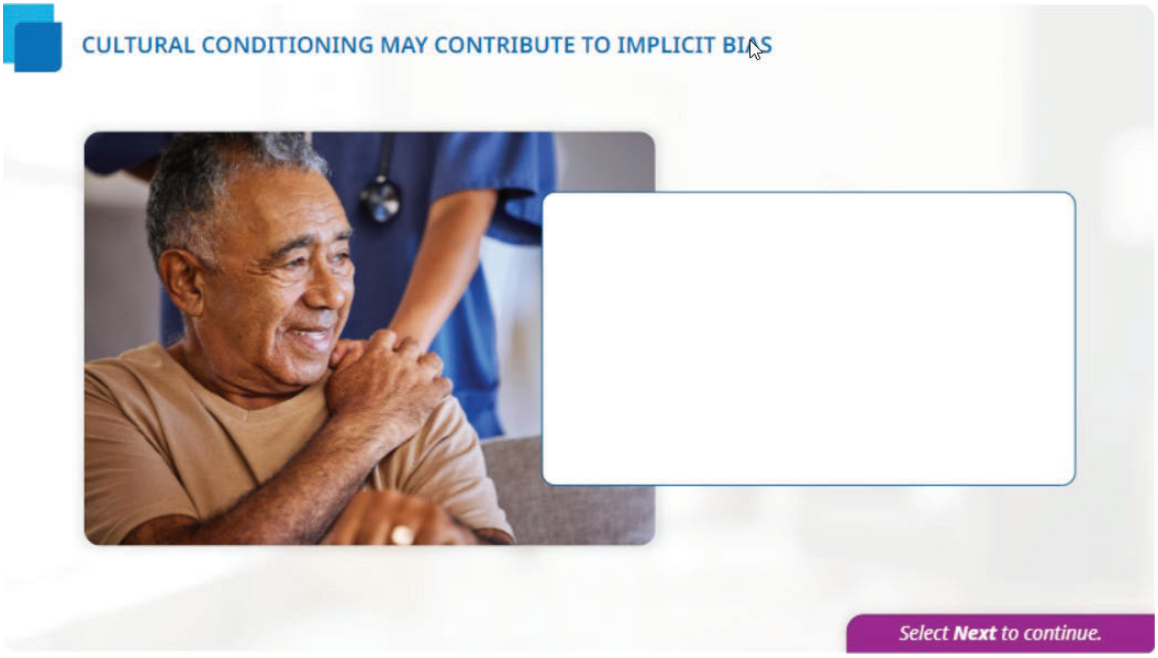
Culture. Shared patterns of thinking, feeling, and acting acquired from common social environments and experiences. Culture is distinct from Race, Ethnicity, or Faith, although culture can be developed through these collective identities and experiences.

Race is a social construct not based on biology that groups people based on physical characteristics, such as skin color and physical features.

Ethnicity refers to large groups of people with common national, tribal, religious, linguistic or cultural backgrounds. Like race, it is not based on biology.

Religion, the shared belief in religious doctrines or spirituality, also plays a part in cultural identity and how communities connect.

2.6 Cultural Conditioning May Contribute to Implicit Bias



Notes:

As we go through life, we continue to pick up cues from our family, peers, community, and colleagues about what to think, believe, and how to act. This is called cultural conditioning. The process of cultural conditioning is typically unconscious, invisible, and ongoing.

Because cultural conditioning is often unconscious, we aren't always aware of the beliefs or preferences we form as a result. This can result in implicit biases, or prejudices in favor of or against a person or group that occur unconsciously and unintentionally, but nevertheless affects judgments, decisions, and behaviors.

Everyone has implicit biases. Implicit biases can be positive, such as a preference for something or someone. They can also be negative, such as an aversion towards something or someone. An example of implicit bias is making assumptions on one's physical abilities based on their age.

Examples of how implicit bias can present in health care include when we automatically expect certain groups to have poorer health outcomes, or when we assume certain groups are exaggerating their symptoms or level of pain.

2.7 Cultural Humility Leads to Better Care



Notes:

There is an increasing level of diversity, or differences among people and groups, in the healthcare system, which requires a high level of cultural competency and humility among staff and providers. Cultural humility offers a pathway and a framework to better serve all members' health needs.

Increasing one's cultural humility involves:
- Self-awareness, or being willing to reflect on your own identity, culture, conscious and unconscious biases;
- Empathy, or being willing to see and understand the world through the experiences of others;
- Cultural Curiosity, or appreciating and being interested in the variance in cultures within your organization;
- Growth Mindset or showing a willingness to recognize and learn from cultural missteps and mistakes, and actively seeking opportunities for growth.

Everyone within the healthcare system benefits from the practice of cultural humility. Overall, cultural humility leads to improved understanding, and more appropriate treatment recommendations, which in turn, leads to:
- Increased efficiency
- Improved member and provider satisfaction
- Improved member health and safety
- Reduced health disparities, and
- Decreased costs to the healthcare system

2.8 Apply What You Learned

APPLY WHAT YOU LEARNED

Scenario:

You are a health care provider treating a patient named Omar who practices a religion that involves specific dietary restrictions. During the consultation, you assess that the patient's diet might be contributing to his health condition. You recommend dietary changes, but Omar expresses concern, saying, "I'm not sure I can follow these recommendations because they conflict with my religious beliefs."



Notes:

Review the scenario and provide an answer to the question that follows.

Scenario:
You are a health care provider treating a patient named Omar who practices a religion that involves specific dietary restrictions. During the consultation, you assess that the patient's diet might be contributing to his health condition. You recommend dietary changes, but Omar expresses concern, saying, "I'm not sure I can follow these recommendations because they conflict with my religious beliefs."

APPLY WHAT YOU LEARNED

How would you approach this situation to demonstrate cultural humility and work with the patient to develop a suitable care plan?

Select one answer then select SUBMIT.

- ○ Tell the patient that you are unable to provide effective care if they don't follow the recommended diet.
- ○ Ask the patient to explain their dietary restrictions and explore alternative dietary recommendations that align with both their health needs and religious practices.
- ○ Suggest that the patient try a popular diet trend, regardless of their existing dietary needs or preferences.
- ○ Advise the patient that their health is the top priority and suggest they consult with a religious leader to seek an exception to their dietary restrictions.

Correct	Choice
	Tell the patient that you are unable to provide effective care if they don’t follow the recommended diet.
	Advise the patient that their health is the top priority and suggest they consult with a religious leader to seek an exception to their dietary restrictions.
X	Ask the patient to explain their dietary restrictions and explore alternative dietary recommendations that align with both their health needs and religious practices.
	Suggest that the patient try a popular diet trend, regardless of their existing dietary needs or preferences.

Feedback when correct:

Great choice! Asking the patient about his dietary restrictions and exploring alternatives shows cultural humility and respects his beliefs while focusing on his health.

Feedback when incorrect:

Unfortunately, that’s incorrect. Stating that effective care depends on following a diet overlooks the patient's individual needs and beliefs.

3. Lesson 2

3.1 Lesson 2: Cultural Communities Within the CalOptima Health Membership

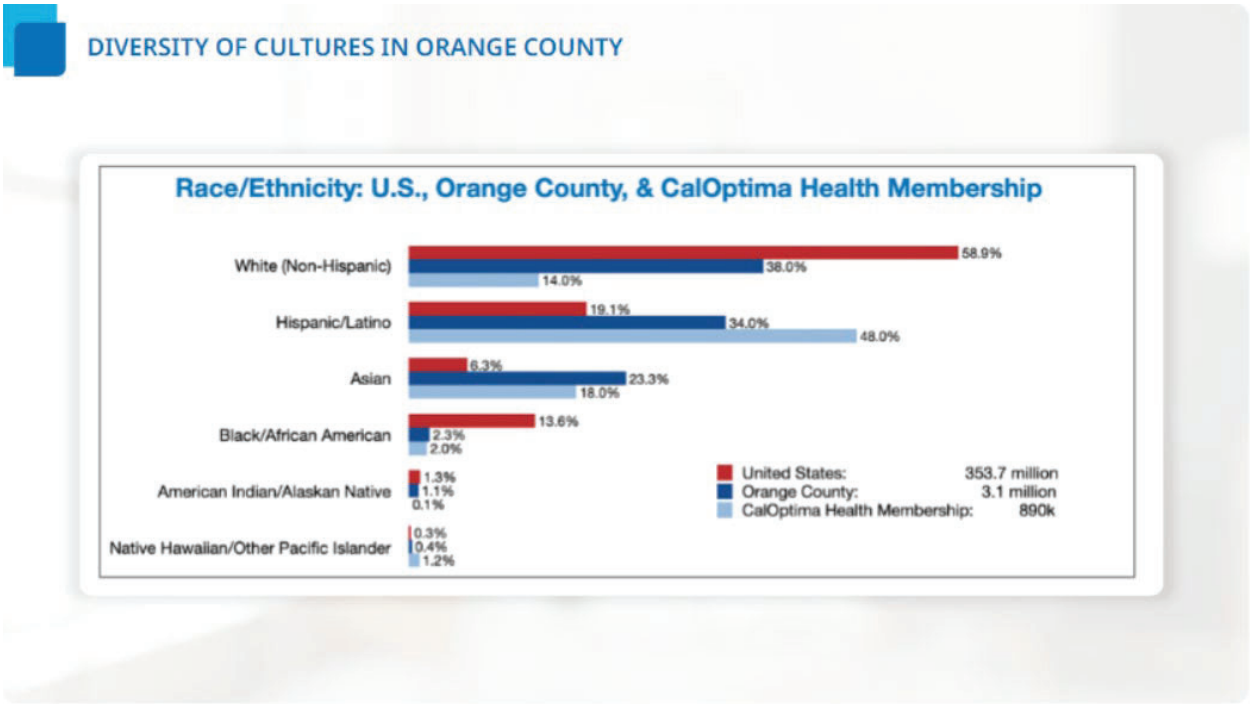


Notes:

Lesson 2: Cultural Communities Within the CalOptima Health Membership

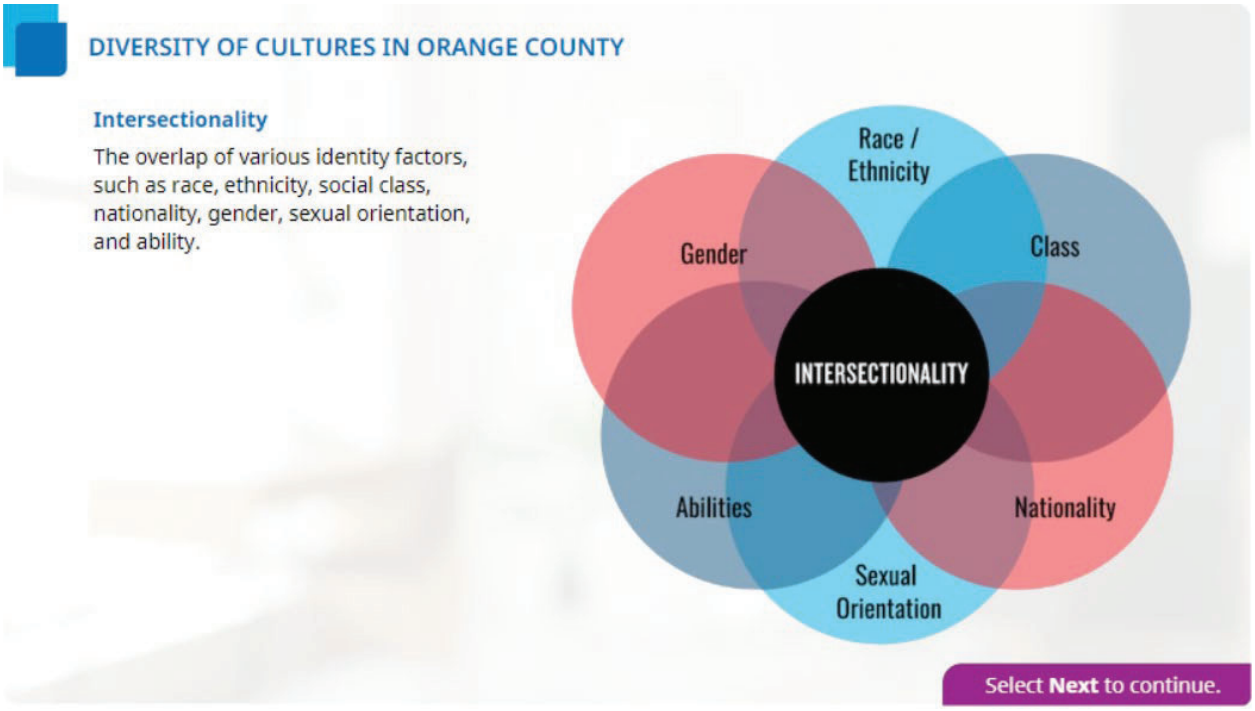
In this lesson, we will learn about the diversity of cultures present in Orange County and within CalOptima Health's membership. Given that this is a short introductory training, we are only able to describe our member population at a high level and use relatively broad group categorizations. We encourage you to take a deeper dive after the training to fully appreciate the depth and richness of diversity among our members. To inform this learning journey, resources will be available to you at the end of the module.

3.2 Diversity Of Cultures In Orange County



Notes:

The first aspect of diversity that we will explore is race and ethnicity. This chart provides a broad overview of racial and ethnic representation within CalOptima Health's membership as well as a comparison of Orange County to the broader United States. You can also see how many Orange County residents identify as 'two or more races', which relates to the concept of intersectionality



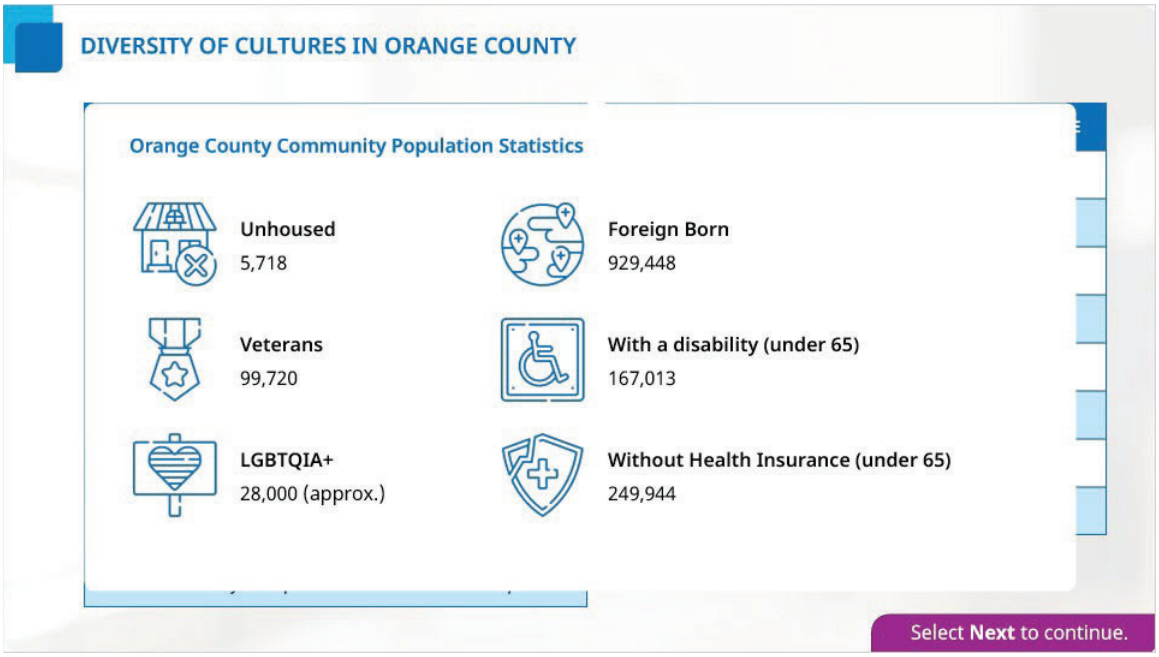
Notes:

Intersectionality refers to the overlap of various identity factors, such as race, ethnicity, social class, nationality, gender, sexual orientation, faith, and ability. In this case, intersectionality refers to having two or more racial identities.

However, intersectionality can also encompass a combination of non-racial identity traits, such as being a gay Black man or a white Christian woman living in poverty.

The intersection of various identity factors contributes to the multiple layers and qualities that make each of our members unique. Approaching individuals with humility and striving to understand their complex identities will help build rapport and trust in the relationship.

3.3 Diversity Of Cultures In Orange County



Notes:

Next, Orange County's diversity is reflected in the many languages spoken by CalOptima Health's members. The left column lists the languages spoken by our members, while the right column reflects members' preferred language.

A significant percentage of CalOptima Health members prefer a language other than English, highlighting the need for linguistic sensitivity in order to be culturally competent, a topic we will return to later in this course.

Finally, this chart provides figures about additional cultural communities that exist within Orange County, including veterans, people who have immigrated to the US, people with disabilities, and LGBTQIA+.

3.4 Background On Cultural Communities In Orange County



Notes:

We will explore a few main cultural groups serviced by CalOptima Health to give you a sense of the people you might interact with. Note, however, that these groups are by no means the only ones we serve.

Also, these broad categories have several subgroups under them. The subgroups may intersect but each have their own distinct qualities, differences in lived experiences, beliefs, health behaviors and genetic predispositions. In future trainings, we will take a closer look at the subgroups.

Navigate through each group to learn more.

Asian American and Pacific Islander (AAPI) is a term used to describe people of Asian or Pacific Islander descent in the U.S. In Orange County, the largest AAPI subgroups by ethnicity are Vietnamese, Chinese, Filipino, and Korean.

According to the CDC, "A disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them." A disability can be caused by a variety of factors and can take on many forms, from physical limitations to learning disabilities to intellectual differences like neurodivergence.

LGBTQIA+ is an acronym for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual. The plus refers to sexual orientation or gender identities that may not fit into those that are mentioned.

Hispanic, Latino, and Chicano have different meanings that are often incorrectly used interchangeably. Hispanic refers to those who speak Spanish and may hail from a wide range of countries and cultures, while Latino might be preferred by those originating from Latin America. You may also hear the term Chicano, which is used to identify people of Mexican descent born in the United States.

Diversity exists within cultural communities as well. For some Spanish-speaking members, Spanish could be a second language to an indigenous language, such as Mam, and it is important to acknowledge that different regions may use words differently.

The South Asian, Middle Eastern, and North African (SAMENA) community is ethnically and linguistically diverse and includes

Arabs, Iranians, Kurds, and Afghans. This group is often excluded from research and discussions about health disparities because they are categorized as White on the US Census.

The terms African American and Black have different connotations. African American might be preferred by Black Americans with a traceable lineage to the continent of Africa, but the term Black may be preferred by those who do not relate or have immediate ties to African heritage such as an immigrant from the Caribbean.

Indigenous Americans and Native Alaskans include people with origins or shared ancestry with any of the original peoples of North, South, and Central America, who maintain tribal affiliation or community attachments. Please note, some Indigenous Americans may not have formal tribal recognition from the United States government, which can impact their lived experience.

The precise age of an Older Adult is not universal. Medicare collects the health information of adults aged 65 and older, while Social Security is available to those who are 62 years old. The U.S. Department of Housing and Urban Development's (HUD) Housing for Older Persons Act (HOPA) manages older adult housing and 55-and-over communities.

3.5 Cross-Cutting Issues Among Cultural Communities: Health Literacy



Notes:

Culture can also shape one's health literacy. Health Literacy is the ability to obtain, process, and understand basic health information. It is critical for making good health decisions.

Fortunately, there are many things you can do to promote health literacy among our members:
1. Use plain language and/or a CalOptima Health Interpreter when necessary
2. Keep written text to a sixth-grade reading level or below and write health information in a manner that makes it easy for members to recall.
3. Use demonstrations, step-by-step graphics, and pictures to accompany what you say or write.
4. Provide additional health literature when appropriate.
5. When appropriate, offer to include caregivers and/or loved ones in the conversation, and
6. Use reflective listening and the 'teach back' method to confirm understanding.

Let's take a moment to explain reflective listening and the 'teach back' method. Used together, they are an excellent way to ensure that you and the other person mutually understand each other.

Reflective listening means that you actively and carefully listen to what a member communicates. Then you 'reflect back,' by synthesizing and relaying what you understood from what they said. An easy way to do so is to say, "If I understood you correctly, you said that."

The 'teach back' method essentially encourages the member to reflectively listen in turn. After you communicate health information or instructions, you invite them to 'teach' you the information or instructions you conveyed. An easy way to start the process is to say, 'Now if I asked you to teach me about what I just explained, what might you say?"

If they are unable to convey the key points of your message, assess what may be causing the gap in understanding, and proceed accordingly. You may want to reframe and retry your message, or you may decide that it is time to contact a CalOptima Health interpreter.

3.6 Cross-Cutting Issues Among Cultural Communities: Use of Alternative and Complementary Medicine



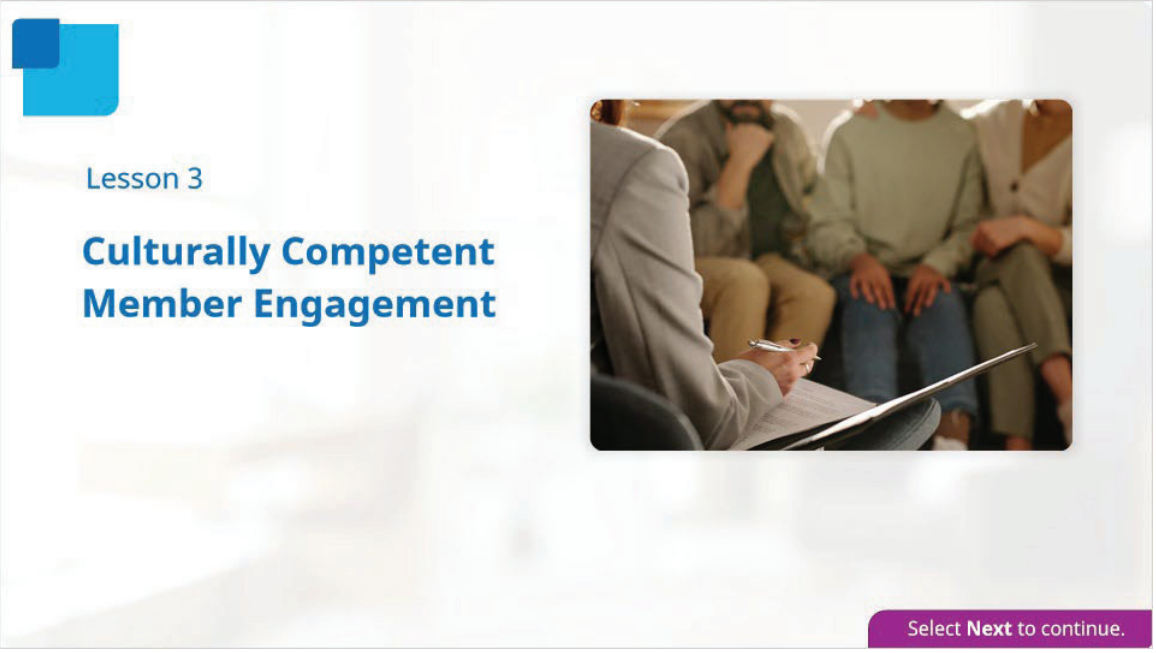
Notes:

Based on cultural or personal preference, members may opt for alternative or complementary medicine as part of their care, such as acupuncture, tai chi, yoga, massage therapy, meditation, vitamins, nutritional therapies, and traditional cultural healing practices.

Part of understanding and respecting members' culture is to engage with beliefs and practices in a respectful way. Encourage members to talk to their provider about starting any kind of treatment, including alternative and complementary therapies, to assess their safety and efficacy.

4. Lesson 3

4.1 Lesson 3: Culturally Competent Member Engagement

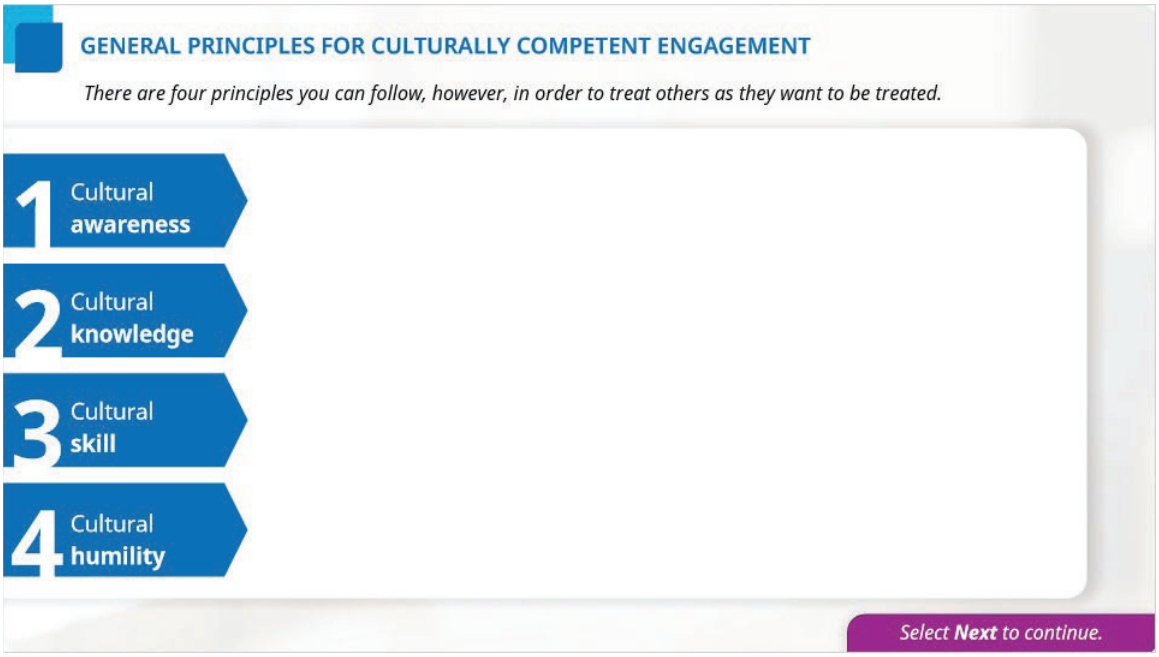


Notes:

Lesson 3: Culturally Competent Member Engagement

In this lesson, we discuss considerations for engaging specific cultural communities.

4.2 General Principles for Culturally Competent Engagement



Notes:

The purpose of cultural competence and cultural humility is to be adaptable and responsive to differences, so it's impossible to give blanket advice for how to be culturally competent in every situation. There are four principles you can follow, however, in order to treat others as they want to be treated.

Select each tab to learn more.

L1: Cultural Awareness (Slide Layer)



Notes:

Cultural awareness: Reflect on your own cultural and professional background, and beliefs about other cultures, especially those represented in your community. Develop insight into cultural health care values.

L2: Cultural Knowledge (Slide Layer)



Notes:

Cultural knowledge: Acquire information about other cultures and communities. Read journal articles and textbooks, attend seminars and workshops, and use online resources and courses.

L3: Cultural Skill (Slide Layer)



Notes:

Cultural skill: Commit to applying the knowledge and skills you learn in this course to your day-to-day responsibilities and interactions with members.

L4: Cultural Humility (Slide Layer)



Notes:

Cultural humility: Be willing to respect and accept cultural differences; ask members about their preferences and

perspectives, and remain open to continual learning.

4.3 Members Facing Stigma and Discrimination About a Condition



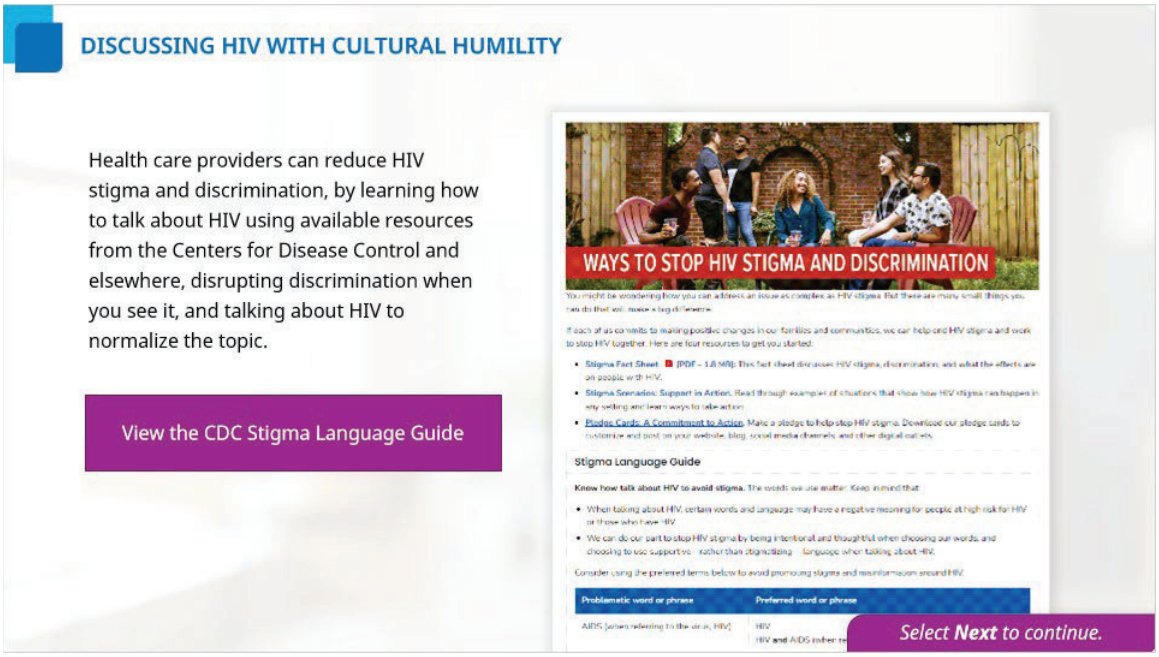
Notes:

Cultural competency is critical when engaging with members facing health condition-related stigma or discrimination. Condition-Related Stigma refers to negative attitudes and beliefs about people with a specific medical condition, while Condition-Related Discrimination is the act of treating people living with a specific medical condition differently than those without.

Examples of condition-based discrimination include: assuming someone caused their own lung cancer through smoking, or stating that all people experiencing homelessness have mental illness.

A community that continues to face stigma and discrimination is those living with HIV. An example of HIV-related stigma includes believing that only certain groups of people can get HIV. Discriminatory behavior includes a provider refusing to give care to a person living with HIV, or socially isolating a member of a community because they are HIV positive.

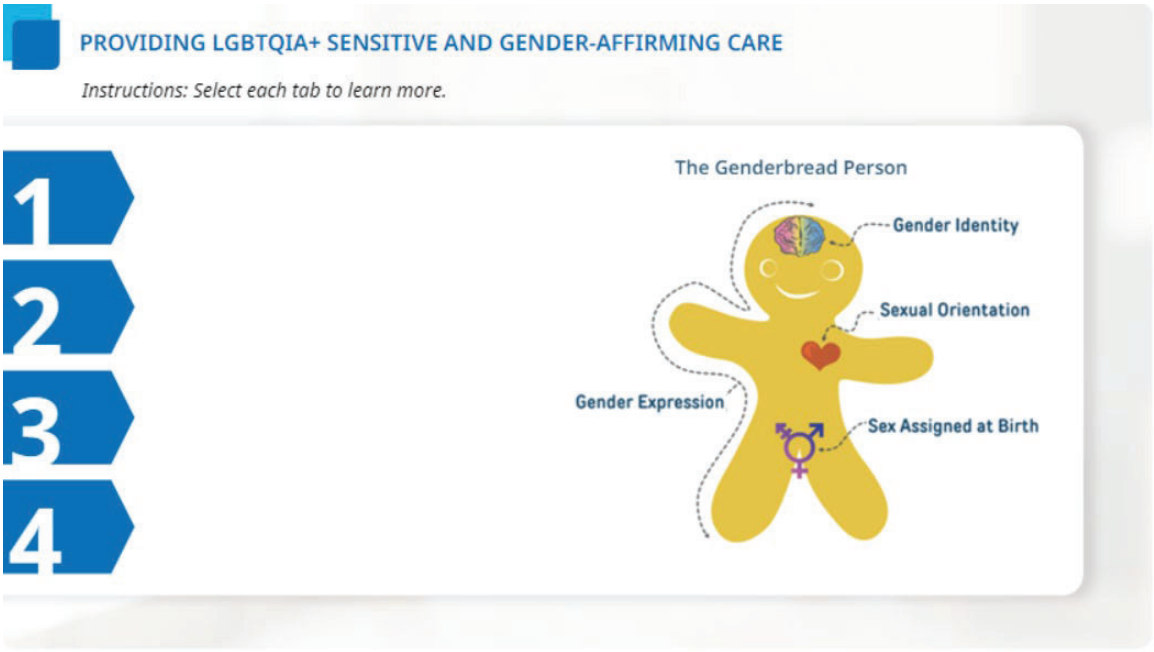
4.4 Discussing HIV with Cultural Humility



Notes:

Health care providers can reduce HIV stigma and discrimination, by learning how to talk about HIV using available resources from the Centers for Disease Control and elsewhere, disrupting discrimination when you see it, and talking about HIV to normalize the topic.

4.5 Providing LGBTQIA+-Sensitive and Gender-Affirming Care



Notes:

Now, we will spotlight a couple of groups that reflect CalOptima Health's members who may have experienced discrimination within health care and explore how to engage these groups with cultural competence and humility.

The first step in providing LGBTQIA+-sensitive and gender-affirming care is ensuring that you have a necessary understanding of the concepts of gender, sex, and sexual orientation.

This image can be a helpful tool to use. Select each tab to learn more.

_____

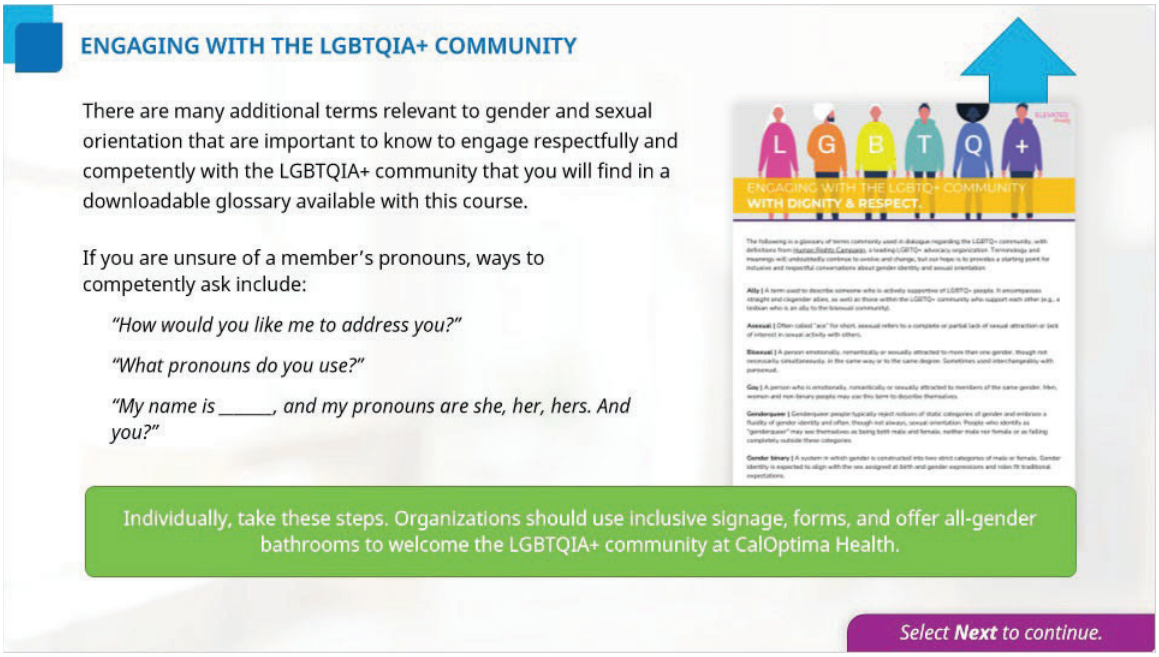
Sex assigned at birth: The designation given to an infant often based on the anatomical and other biological characteristics. You may hear this term referred to as birth sex, natal sex, biological sex, or sex; however, sex assigned at birth is recommended.

Gender Identity: An individual's internal conception of being male, female, both, neither, or any combination thereof.

Gender Expression: The way a person communicates their gender to the world through mannerisms, clothing, speech, behavior, etc. Gender expression varies depending on culture, context, and historical period.

Sexual Orientation: An enduring emotional, romantic, or sexual attraction to other people.

4.6 Engaging with the LGBTQIA+ Community



Notes:

There are many additional terms relevant to gender and sexual orientation that are important to know to engage respectfully and competently with the LGBTQIA+ community that you will find in a downloadable glossary available with this course.

Inclusive language also includes using members' correct pronouns.

If you are unsure of a member's pronouns, ways to competently ask include:
- "How would you like me to address you?"
- "What pronouns do you use?"

- "My name is _____, and my pronouns are she, her, hers. And you?"

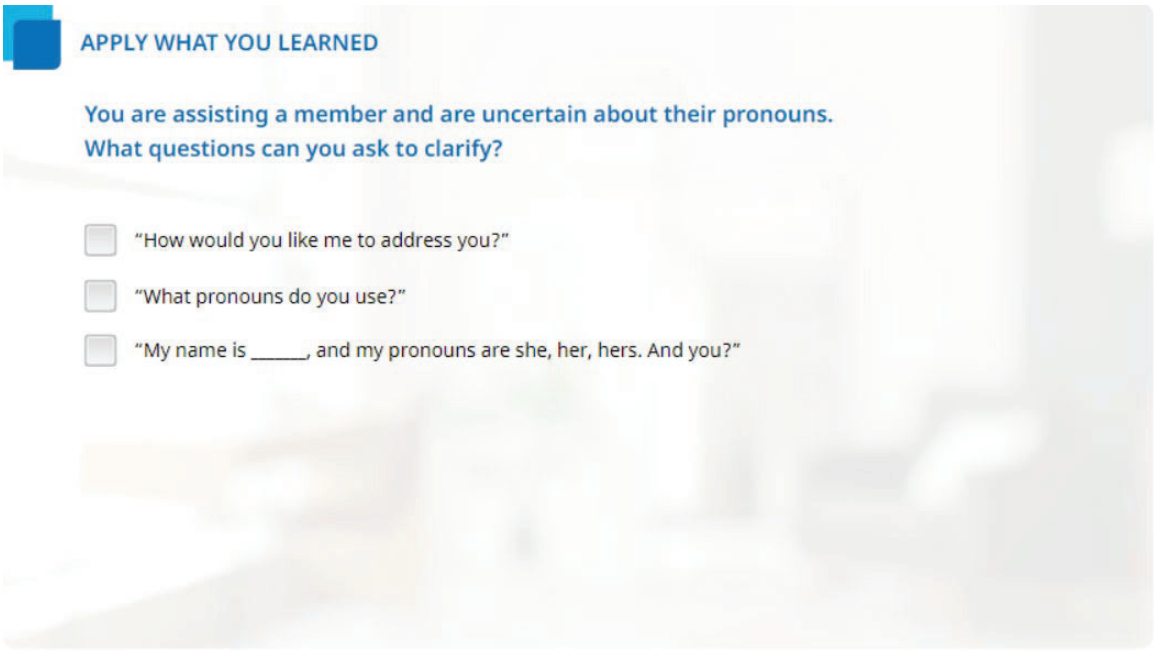
If you discover that you have used the wrong pronouns for someone, simply apologize and affirm the correct pronoun. And if you don't have an opportunity to ask, simply avoid using a pronoun and use the person's name instead.

Additional considerations for providing gender-affirming care include avoiding honorifics like Sir, Ma'am or Miss; and avoiding gender-binary language. Use 'partner or spouse' instead of 'husband or wife' and 'folks' instead of 'ladies and gentlemen' or 'guys.'

These recommendations represent steps you can take at an individual level. At a practice or organizational level, it's recommended that signage and intake forms use inclusive images and language, and there are all-gender bathrooms available to ensure that members of the LGBTQIA+ community feel welcomed and included in the greater CalOptima Health community.

4.7 Apply What You Learned

(Multiple Response, 10 points, 1 attempt permitted)



Notes:

Apply what you learned.
You are assisting a member and are uncertain about their pronouns. What questions can you ask to clarify?
Select all that apply, then select SUBMIT.

Correct	Choice
X	"How would you like me to address you?"
X	"What pronouns do you use?"

Correct	Choice
X	“My name is _____, and my pronouns are she, her, hers. And you?”

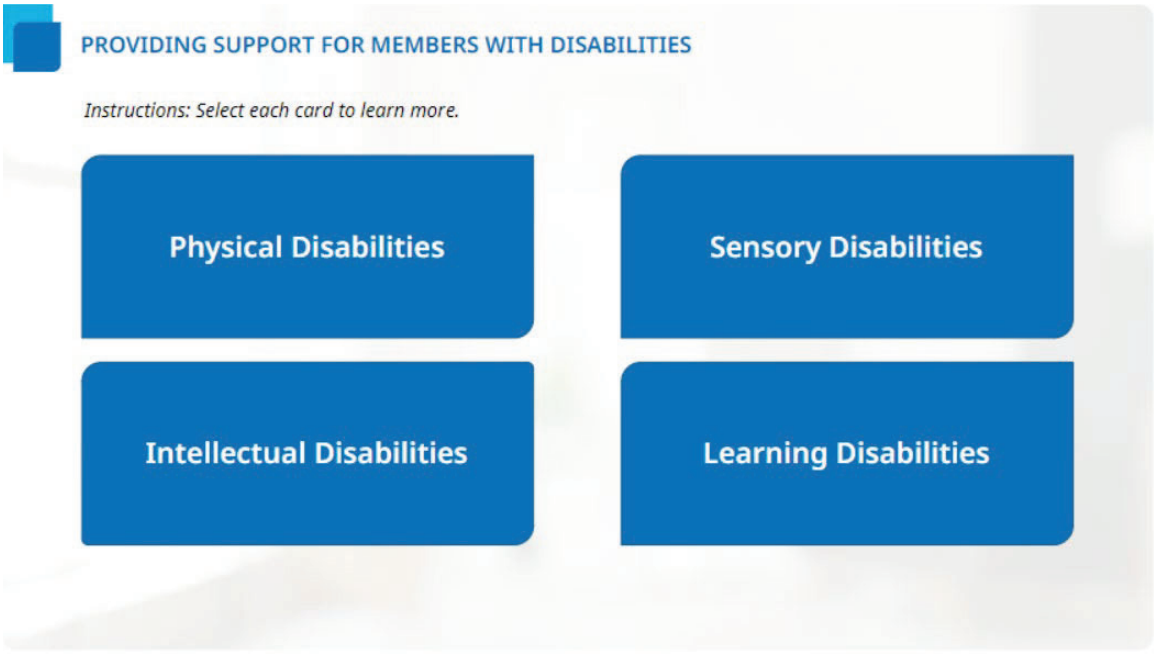
Feedback when correct:

All of these are respectful ways to ask about someone's pronouns. Asking directly, sharing your own pronouns, and allowing the person to guide how they want to be addressed shows care and respect for their identity.

Feedback when incorrect:

All of these are good questions to ask when you're unsure of someone's pronouns. It's important to ask directly, share your own pronouns, and let the member guide how they'd like to be addressed. This approach fosters respect and inclusion.

4.8 Providing Support for Members with Disabilities



Notes:

In health care, cultural competency involves understanding, respecting, and appropriately responding to the unique needs of all members, including those with disabilities.
It's crucial to recognize that disabilities encompass a wide range of physical, sensory, cognitive, and mental health conditions.

Select each card to learn more.

Physical Disabilities affect a person’s mobility, dexterity, or stamina.

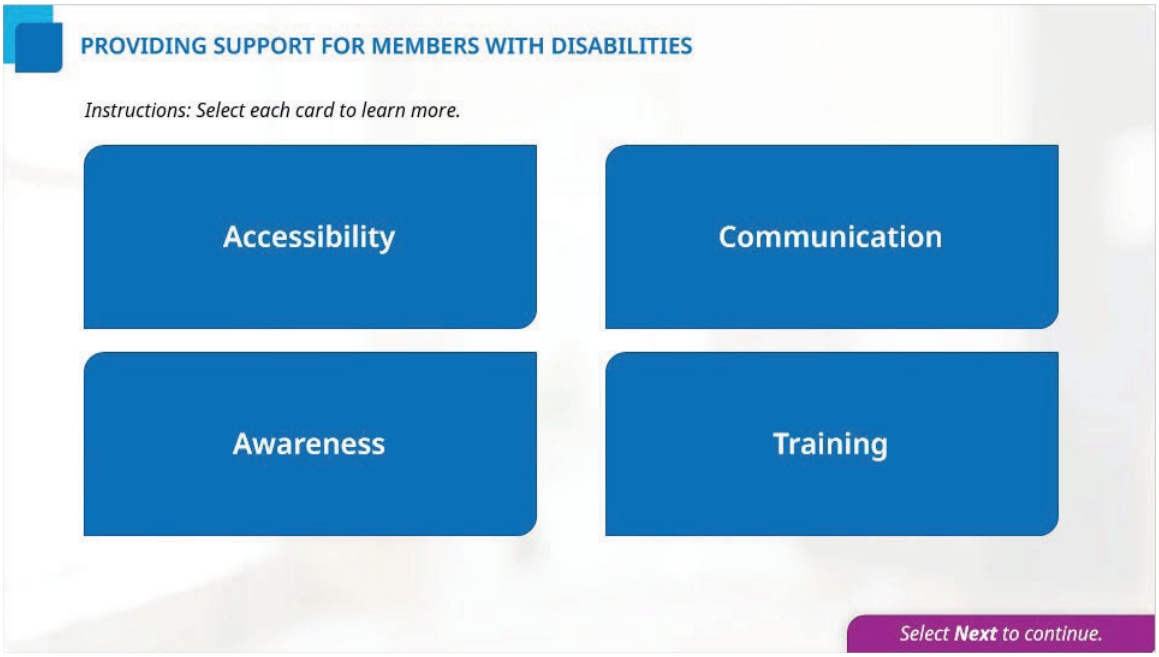
Sensory Disabilities affect one or more of the senses: sight, hearing, touch, smell, and taste.

Intellectual Disabilities affect intellectual functioning and adaptive behavior.

Learning disabilities affect how a person learns new information, understands complex information, and expresses knowledge.

Note that certain conditions may also create disabilities, for example, mental health disorders that affect a person's thinking, feeling, mood, or behavior may rise to the level of affecting a person's ability. Chronic Illnesses can also impact one's ability, daily life, and health.

4.9 Providing Support for Members with Disabilities



Notes:

Organizations and individuals should consider the following when engaging with people with disabilities to ensure they are treated with respect and given equal care.

Select each card to learn more.

_____

Accessibility: Ensure all healthcare facilities and information are accessible to people with various disabilities.

Communication: Use appropriate methods to communicate effectively with members with different disabilities.

Awareness: Understand members' unique needs and preferences.

Training: Continuously educate healthcare staff on disability awareness and cultural competency to provide the best care possible.

4.10 Providing Support for Members with Disabilities



Notes:

Moreover, healthcare providers should be aware of and challenge any biases or assumptions they might hold about people with disabilities.

By fostering an inclusive environment, we not only improve the quality of care but also promote dignity and respect for all members. Remember, cultural competency is not just about awareness but also about taking active steps to ensure equitable and personalized care for everyone.

5. Lesson 4

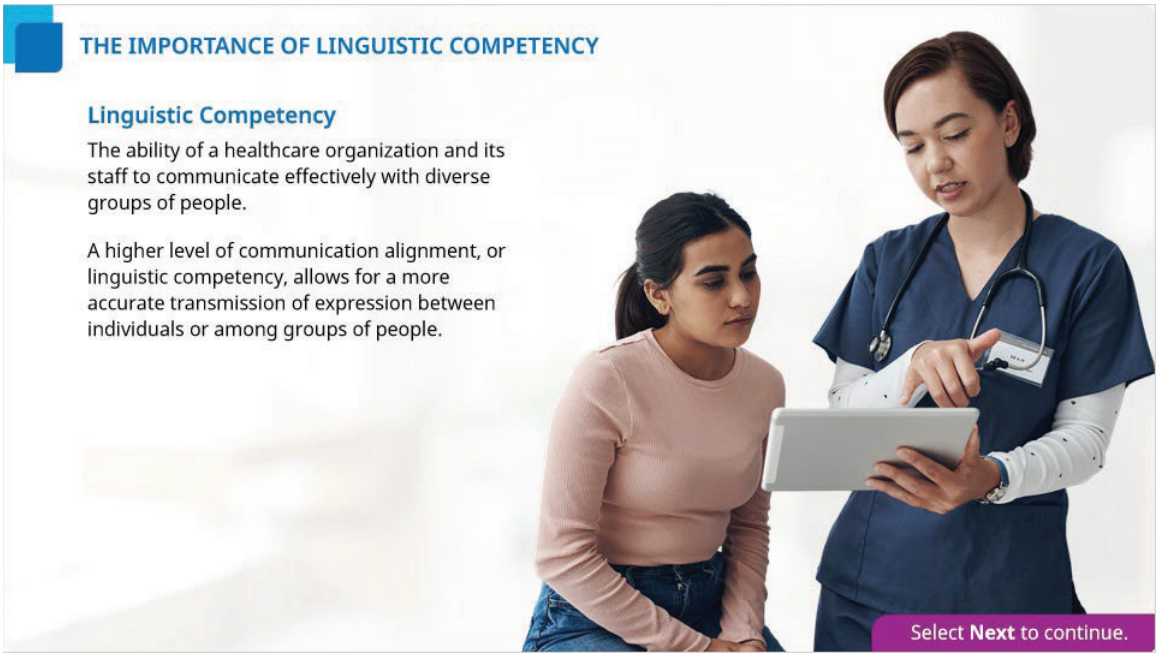
5.1 Lesson 4: Linguistic Competence and Available Language Services



Notes:

Lesson 4: Linguistic Competence and Available Language Services

5.2 The Importance of Linguistic Competency



Notes:

For a healthcare system or organization to be culturally competent, it must be linguistically competent. Linguistic competency is the ability of a healthcare organization and its staff to communicate effectively with diverse groups of people.

Every culture will use some form of language or communication method to express thoughts, feelings, information, ideas, stories, and more. A higher level of communication alignment, or linguistic competency, allows for a more accurate transmission of expression between individuals or among groups of people.

5.3 Methods of Communication



Notes:

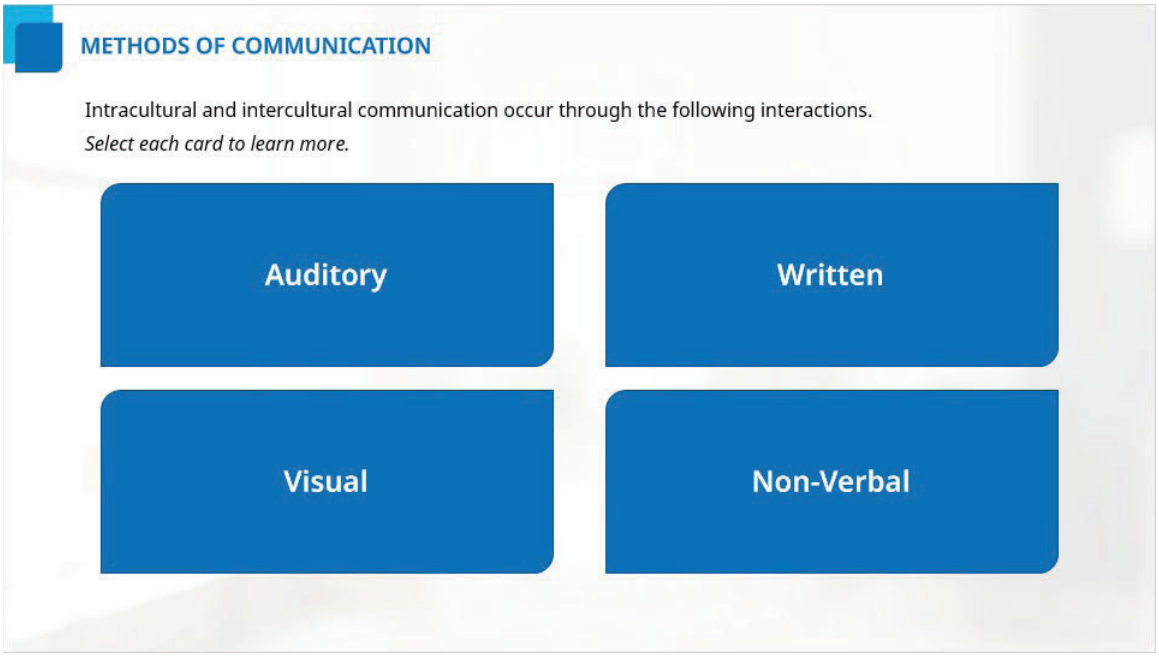
Let's take a few moments to consider how your native language and a member's native language play a significant role in day-to-day communication.

To begin with, native languages are an important aspect of an individual's identity and help to connect speakers in that group with others.

When people are communicating within the same cultural group, with shared norms and values, they are taking part in intracultural communication.

When communication is taking place between people from different cultures, with emphasis on cultural sensitivity and awareness, they are practicing intercultural communication.

5.4 Methods of Communication



Notes:

Both intracultural and intercultural communication can take place through one or more of the following ways:

Select each card to learn more.

_____

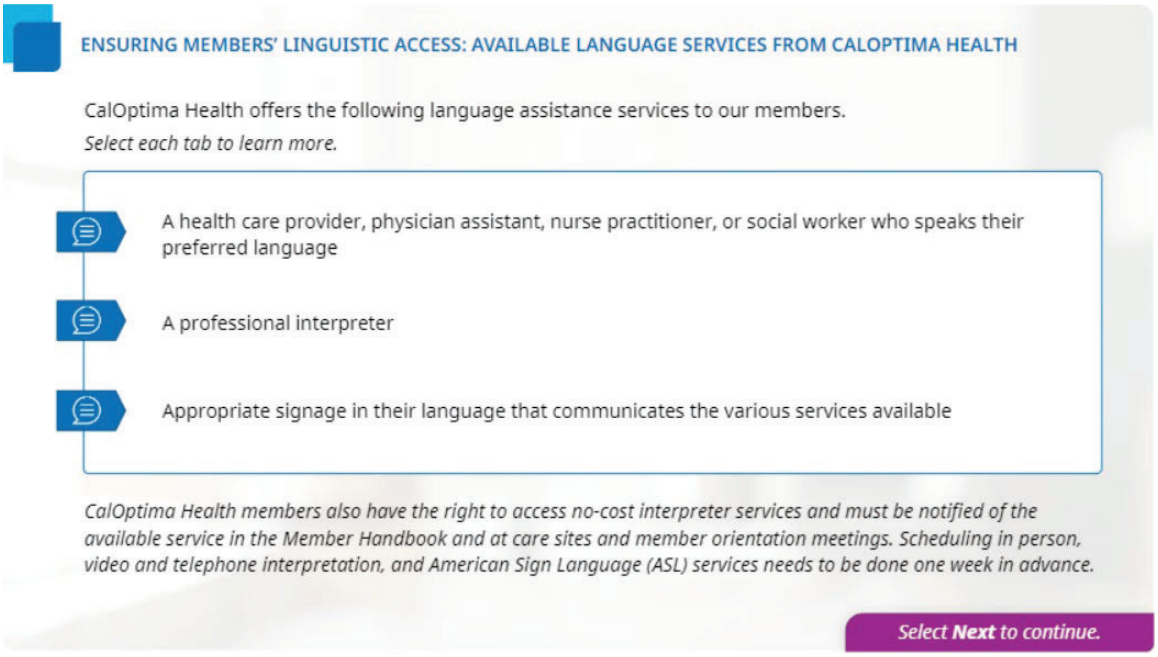
Auditory communication: The exchange of information through spoken words, sounds, or other auditory signals, to enable interaction and understanding between individuals or among groups of people.

Written communication: The exchange of information through written symbols, such as text, to convey messages.

Visual communication: Allows for the transfer of information and ideas through visual elements, such as images, pictures, videos, or charts and graphs, to enhance understanding.

Non-verbal communication: The transmission of messages and emotions without the use of spoken or written words. Non-verbal communication relies on body language, gestures, facial expressions, and other visual cues.

5.5 Ensuring Members' Linguistic Access: Available Language Services From Caloptima Health



Notes:

CalOptima Health meets members' linguistic needs in a variety of ways. Everyone who works for and with CalOptima Health needs to know about the language services available so that we can facilitate access for members who need it.

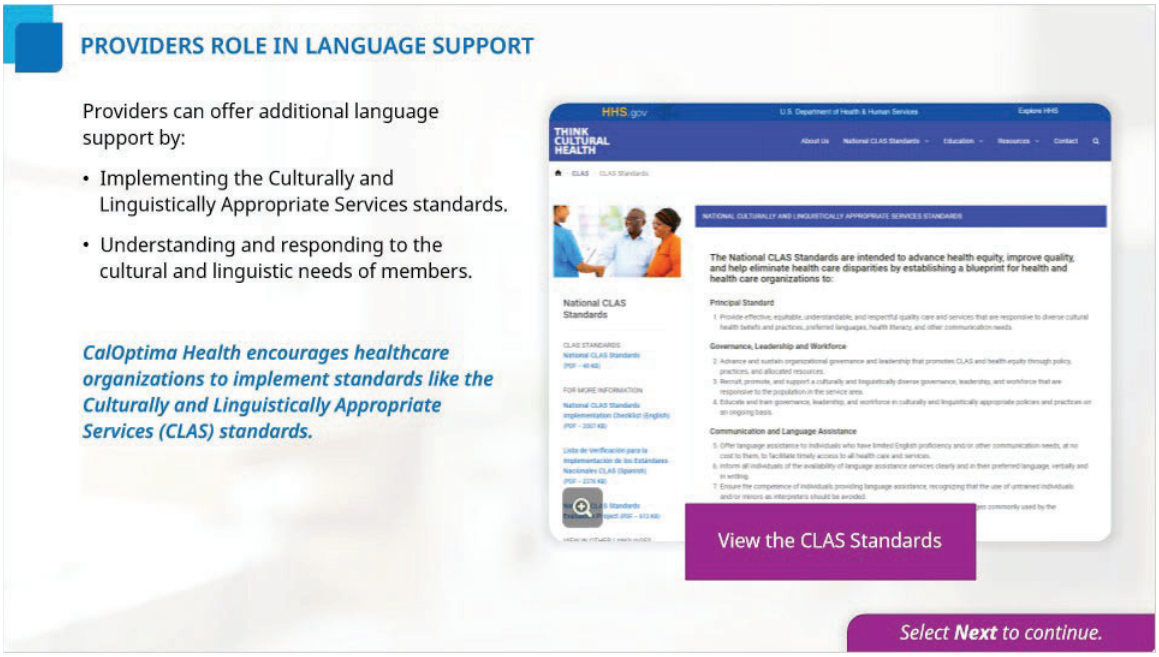
A CalOptima Health member with a language preference other than English may need or want the following:

Select each to learn more.

- A health care provider, physician assistant, nurse practitioner, or social worker who speaks their preferred language
- A professional interpreter
- Appropriate signage in their language that communicates the various services available

CalOptima Health members also have the right to access no-cost interpreter services and must be notified of the available service in the Member Handbook and at care sites and member orientation meetings. Scheduling in person, video and telephone interpretation and American Sign Language (ASL) services needs to be done one week in advance.

5.6 Providers Role in Language Support



Notes:

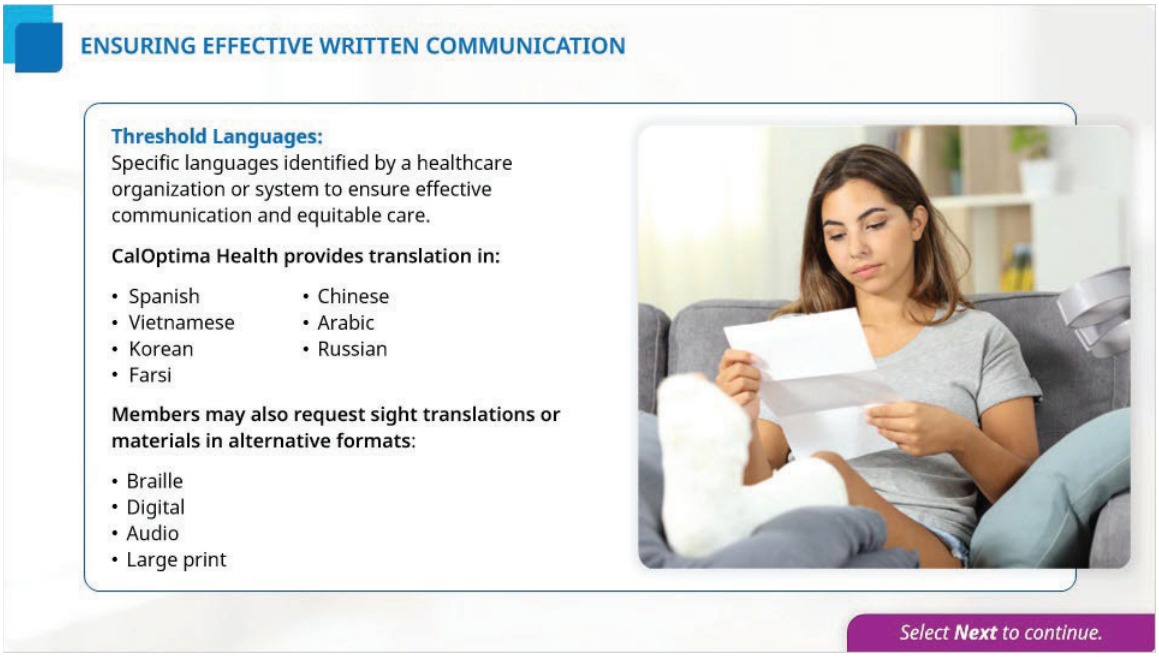
Providers play an important role in understanding the language needs of our members. CalOptima Health monitors our non-English speaking members' ability to obtain health care services through our Language Study Analysis. This analysis of adequacy is based on a standard ratio of providers to members and determines if the standard has been met for each threshold language.

As an organization, CalOptima Health adheres to the Culturally and Linguistically Appropriate Services (CLAS) standards. These include the recommendations and standards disseminated by the Office of Minority Health of the U.S. Department of Health and Human Services (HHS).

CalOptima Health encourages health care organizations to implement standards like the Culturally and Linguistically Appropriate Services standards.

CalOptima Health helps health care providers and health care organizations to deliver culturally competent care as defined by the Office of Minority Health as the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by members to the health care encounter.

5.7 Ensuring Effective Written Communication



Notes:

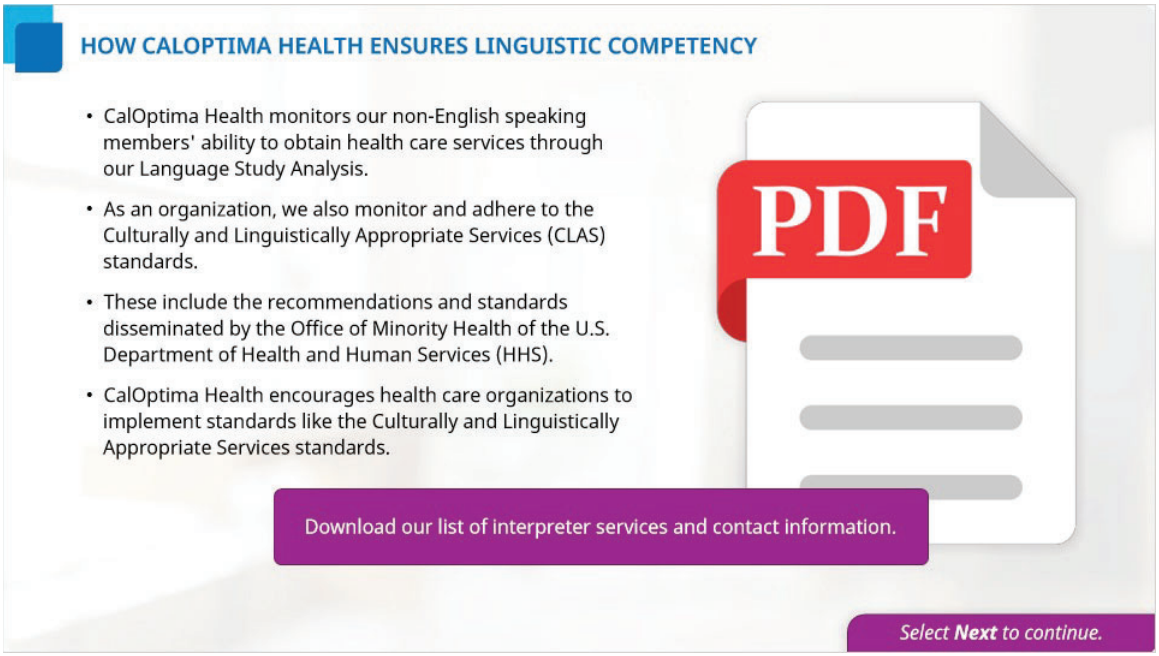
It is equally important that we ensure effective written communication to and for our members.

First, we provide translations of vital documents in our threshold languages.

Threshold languages are specific languages identified by a healthcare organization or system that must be accommodated to ensure effective communication and equitable care. These languages are determined based on the population served and are typically spoken by a significant portion of the member population. Our threshold languages are Spanish, Vietnamese, Korean, Farsi, Chinese, Arabic, and Russian.

Members may also request sight translations or materials in alternative formats such as Braille, digital, audio or large print.

5.8 How CalOptima Health Ensures Linguistic Competency



Notes:

CalOptima Health monitors our non-English speaking members' ability to obtain health care services through our Language Study Analysis. As an organization, we also monitor and adhere to the Culturally and Linguistically Appropriate Services (CLAS) standards. These include the recommendations and standards disseminated by the Office of Minority Health of the U.S. Department of Health and Human Services (HHS). CalOptima Health encourages health care organizations to implement standards like the Culturally and Linguistically Appropriate Services standards.

6. Conclusion

6.1 Congratulations and Key Take-Aways



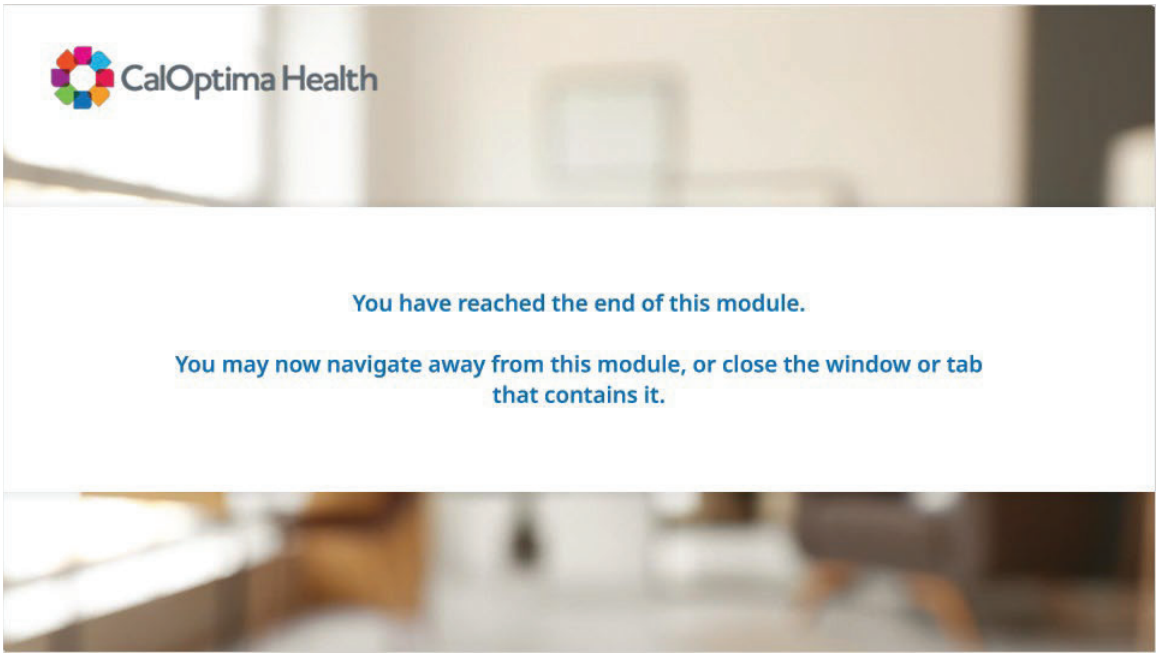
Notes:

This brings us to the end of the course. Congratulations.

As you return to your important roles at CalOptima Health, we hope you carry these key takeaways from the course:

1. CalOptima Health strives to be a culturally competent system, which means that our contributing organizations and individuals actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds.
2. We also strive for cultural humility, which means acknowledging that one does not know and is willing to learn from members about their experiences. A major principle of cultural humility involves working in conjunction with natural, informal or formal partnerships with patients and communities and incorporating their voices.
3. We have many diverse cultures represented in our membership. We have a responsibility to continually educate ourselves about the unique attributes of each culture, intersectional identities, and how to interact effectively.
4. CalOptima Health meets members' linguistic needs in a variety of ways. Everyone who works for and with CalOptima Health needs to know about the language services we offer so that we can facilitate access for members who need it.

6.2 End of Course



Notes:

You have reached the end of this module. You may now navigate away from this module, or close the window or tab that contains it.