CHOC Health Alliance

PROVIDER MANUAL

2025

Last Updated: 01/2025

INTRODUCTION TO MEDI-CAL, CALOPTIMA HEALTH AND CHOC HEALTH ALLIANCE

Medi-Cal

Medi-Cal is California's Medicaid program for low-income families, children, seniors and people with disabilities. 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 DHCS contracts with a managed care health plan to administer services through established networks of organized systems of care. 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.

Website: www.medi-cal.ca.gov

CalOptima Health

CalOptima Health is a county organized health system (COHS) that manages programs funded by state and federal governments but operates independently. They deliver quality health care services to residents in Orange County. Eligible members can enroll with CalOptima Health Direct, CalOptima Health Community Network, or a participating Health Network.

Website: www.caloptima.org

CHOC Health Alliance (CHA)

CHA is a Physician Hospital Consortium (PHC) that coordinates medical services for Orange County's pediatric and young adult Medi-Cal recipients from birth to 21 years of age. CHA is comprised of CHOC Children's Hospital of Orange County and the CHOC Physicians Network (CPN), an independent organization of contracted primary care physicians, specialists, ancillary providers, and allied health professionals. Members must use the providers in their network when care is needed.

Website: www.chochealthalliance.com

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SECTION A: CONTACT INFORMATION

A1: CHOC Health Alliance Contacts

Resources	**Contact Information**
Care Coordination/Care Management Referrals	CHACM@choc.org Fax: (714) 628-9199
Claims Department	(800) 387-1103, **Option 1**
Claims – Paper submission or Corrected Claim submission Via Mail	Rady Children's Hospital – San Diego Attn: CHOC/CPN Claims P.O. Box 1598 Orange, CA 92856
Claims – Paper submission or Corrected Claim submission Via Physical Delivery	Rady Children's Hospital – San Diego Attn: CHOC/CPN Claims 5898 Copley Dr., Suite 307 San Diego, CA 92111
Claim and Payment Appeals Provider Dispute Resolution (PDR)	(800) 387-1103, **Option 1**
Claims - Dispute or Appeal submission Via Mail	Rady Children's Hospital – San Diego Attn: CHOC /CPN Claims 3020 Children's Way, MC 5144 San Diego, CA 92123
Claims - Dispute or Appeal submission Via Physical Delivery	Rady Children's Hospital – San Diego Attn: CHOC/CPN Claims 5898 Copley Dr., Suite 307 San Diego, CA 92111
CHOC Health Alliance Administrative Office	(714) 565-5100
CHA Compliance Department	chacompliance@choc.org
CHOC Corporate Compliance Department	(877) 388-8588 compliancehotline@choc.org

ECHO Health Customer Service	(888) 834-3511
Member Services Available 24/7	(800) 424-2462
Member Services for Hearing Impaired TTY/TDD - California Relay Service	Dial 711 or (800) 735-2922 English (800) 855-3000 Spanish
Prior Authorization Department	(800) 387-1103, **Option 2**
Provider Portal (EZ-NET)	https://eznet.rchsd.org
Provider Relations	providerrelations@choc.org
Provider Services Monday – Friday: 8 am-5 pm	(800) 387-1103
Website	www.chochealthalliance.com

SECTION A2: CALOPTIMA HEALTH CONTACTS

Resources	**Contact Information**
General Information	(714) 246-8500
Behavioral Health	(855) 877-3885 (toll-free)
Claims	(714) 246-8600
Direct Claims submission	P.O. Box 11037 Orange, CA 92856
Dual Eligible Claims submission (Crossover Claims)	P.O. Box 11070 Orange, CA 92856
Claims Provider Dispute Resolution submission	P.O. Box 57015 Irvine, CA 92619

Customer Service	(888) 587-8088 (toll-free)
Compliance and Ethics Hotline	(877) 837-4417
Provider Resource Line	(714) 246-8600
Website	www.caloptima.org

SECTION A3: OTHER PROGRAMS AND SERVICE CONTACTS

Resources	**Contact Information**
Medi-Cal Dental Program	(800) 322-6384 (toll-free) TTY: (800) 735-2922 (toll-free) https://dental.dhcs.ca.gov/
Help Me Grow	(866) 476-9025
Medi-Cal Benefits/ Department of Health Care Services (DHCS)	(916) 552-9797
Medi-Cal Rx Customer Service *Pharmacy Benefit*	(800) 977-2273 https://medi-calrx.dhcs.ca.gov/home/
Orange County California Children's Services (CCS)	(714) 347-0300
Orange County Health Care Agency (OC HCA)	(855) 625-4657
Regional Center of Orange County (RCOC) Referrals	(714) 796-5100 Intake: (714) 796-5354 https://www.rcocdd.com/
Vaccines for Children (VFC)	(877) 243-8832
Vision Service Plan (VSP)	Providers: (800) 615-1883 (toll-free) Members: (800) 852-7600 (toll-free)

SECTION B: TOOLS AND RESOURCES

B1: Provider Relations (PR)

PR serves as a liaison between CHA and the provider community. Please feel free to reach out to a PR Representative for any assistance you may need, including, but not limited to:

- Demographic changes
- Provider additions and terminations
- Authorization status
- Payment inquiries
- Member disenrollment
- Quality improvement and patient satisfaction
- Provider Incentive Program
- Provider and staff training

Contact your dedicated PR Representative or email the PR team at providerrelations@choc.org.

B2: CHA Website

Access CHA resources on our website at www.chochealthalliance.com. Resources include, but are not limited to:

- Provider portal link and registration form
- Provider training
- Prior Authorization Form, Provider Dispute Resolution (PDR) Form and other forms
- Best Practices and HEDIS® tools
- Claims and payment information

B3: CHA Provider Portal

EZ-Net

EZ-NET is CHOC Health Alliance's secure provider portal. To access your account, visit https://eznet.rchsd.org.

Use EZ-NET to:

- Verify member eligibility and member's aid code
- Submit authorizations
- Check authorization status
- View claim status

Registration and Support

To register for an EZ-NET account:

- Visit Portal - CHOC Health Alliance
- Download and complete the EZ-NET User Request form
- Email the completed form to EZNetsupport@rchsd.org
- Once access is granted, a notification with instructions will be emailed to the new user

For access and training, contact Provider Relations at providerrelations@choc.org.

SECTION C: NETWORK CERTIFICATION REQUIREMENTS

C1: Overview

Managed Care Plans are required to annually submit documentation to DCHS to demonstrate adequacy of their networks for the upcoming calendar year. DHCS reviews all MCP network submissions and provides assurance of CalOptima Health's compliance with the Annual Network Certification (ANC) requirements to the Centers for Medicare & Medicaid Services before the calendar year begins.

CalOptima Health must complete and submit accurate data and information to DHCS that reflects the entire makeup of all network providers that are reviewed for ANC requirements.

C2: Subcontracted Network Certification Monitoring Activities

CHA is 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.

SECTION D: MEMBER SERVICES

D1: Member Eligibility

Except for emergency services, Providers must verify a member's eligibility on each date of service and prior to rendering services. If a member is not eligible, the provider may not receive payment for services provided on that date.

Verifying Eligibility

Providers have multiple options for verifying a member's eligibility:

Eligibility Verification Systems	
CHOC Health Alliance (CHA)	Provider Portal (EZ-NET): https://eznet.rchsd.org Phone: (800) 387-1103
CalOptima Health	Website: https://provider.caloptima.org/#/login
Medi-Cal	Website: www.medi-cal.ca.gov Phone (AEVS): (800) 456-2387

Member ID Card

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, such as CHA. All members receive this card from CalOptima Health.

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

Front of the card:

- Member's name and Client Identification Number (CIN)
- Member's date of birth
- Member's effective date
- Member's health network and the health network's phone number
- Member's PCP and PCP's phone number

Back of the card:

- Instructions for the member in the event of an emergency
- Member eligibility verification phone number (providers only)
- CalOptima Health Provider Resource Line
- CalOptima Health Customer Service Line (members only)
- Phone numbers for both pharmacy and vision services (card can be used for pharmacy and vision services)

D2: Primary Care Provider (PCP) Assignment

Health Network Selection

Members must complete the Health Network Selection form indicating their choice of Health Network and PCP and return it to CalOptima Health.

If CalOptima Health receives a member's completed 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.

If CalOptima Health receives a member's completed 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.

If a member does not choose a health network, CalOptima Health will auto-assign the member to a Health Network based on a predetermined algorithm.

A member may change his or her Health Network for any reason every 30 days.

PCP Selection

New members can select a PCP at the time of enrollment by calling CHA Member Services at (800) 424-2462, if not already noted on their Health Network Selection form. If no choice is made, CHA auto-assigns the member using an algorithm that considers the member's place of residence, primary spoken language, and other similar factors.

PCP Change Request

Members can change their PCP at any time by calling CHA Member Services. The member, member's parent or legal guardian must make the PCP change request. The provider or office staff cannot make the request on behalf of the member.

If the Member request to change the PCP is received within the first 10 days of the month and the member has not yet received services, the PCP assignment may be made with a retroactive effective date of the first day of the current month. Otherwise, all PCP change requests will be effective on the first day of the following month.

Members may change their PCP every 30 days.

Member Disenrollment

If the member-provider relationship is no longer positive and collaborative, the PCP can request the member's disenrollment (i.e., removal) from their panel.

A disenrollment request may be due to one of the following:

- Non-compliance: A member fails to maintain a satisfactory Member-Provider relationship and continually fails to follow the Provider's recommended treatment or procedure, resulting in deterioration of the member's medical condition and/or jeopardizing their health status; or
- Disruptive behavior: A member exhibits physically threatening or excessively disruptive behavior towards Providers, ancillary or administrative staff, or other Health Network members. The member's behavior must be of sufficient severity that a police report is filed for that behavior.

How to submit a disenrollment request:

- Prior to submitting a request to CHA to disenroll a member due to non-compliance, the provider MUST notify the member in writing regarding the non-compliance.
- Prior to submitting a request to CHA to disenroll a member due to disruptive behavior, the provider must contact the appropriate law enforcement agency to file a report. If possible, attempt to rule out any medical or behavioral health conditions that may contribute to the disruptive or threatening behavior.
- Mail, fax or email a letter to Provider Relations stating detailed information on the reason(s) for requesting disenrollment. The Provider should submit the member's complete medical history with the request to disenroll to CHA, including interventions carried out to diagnose and treat medical and behavioral health problems. Also include a summary of the discussions and correspondence documenting efforts to reconcile issues with the Member.

- If the request fits the criteria, CHA Member Services will notify the member to select a new PCP.

The Provider shall continue to be available for any urgent/emergency services for up to thirty (30) days, while the request is reviewed.

SECTION E: MEMBER RESOURCES

E1: Member Rights and Responsibilities

CHA is required to inform its members of their rights and responsibilities, which are listed in the Member Handbook. Member Documents (caloptima.org)

Providers are required to post the members' rights and responsibilities in the waiting room of the facility in which services are rendered.

CalOptima Health members have the right to:

- Be treated with respect and dignity by all CalOptima Health and provider staff.
- Privacy and to have medical information kept confidential.
- Get information about CalOptima Health, our providers, the services they provide and their member rights and responsibilities.
- Choose a doctor within CalOptima Health's network unless the doctor is unavailable or is not accepting new patients.
- Change Health Plans upon request.
- Talk openly with health care providers about medically necessary treatment options, regardless of cost or benefit.
- Help make decisions about their health care, including the right to say "no" to medical treatment.
- Voice complaints or appeals, either verbally or in writing, about CalOptima Health or the care we provide. There is no time limit to file a complaint. CalOptima Health can assist with filing a complaint or grievance.
- Submit grievances, either verbally or in writing, about CalOptima Health, providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination.
- To request an Appeal of an Adverse Benefit Determination within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.
- Receive fully translated written information including grievances and appeals notices.
- Get oral interpretation services in the language that they understand at no cost.

- Make an advance directive including an explanation as to what an Advance Directive is.
- To have access to Federally Qualified Health Centers (FQHCs), Rural Health clinics (RHCs), Indian Health Services (IHS) Programs outside of CalOptima Health's Network, pursuant to federal law.
- Ask for a State Fair Hearing, including information on the conditions under which a State Fair Hearing can be expedited. CalOptima Health can assist with filing for a State Fair Hearing.
- Have access to their medical record and, where legally appropriate, get copies of, update or correct their medical record.
- Access minor consent services.
- Receive written member information in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format upon request and in accordance with 45 CFR sections 84.52(d), 92.202, and 438.10.
- Have timely access to network providers.
- Be free from any form of control, restraint, seclusion, or limitation used as a means of coercion, discipline, pressure, punishment, convenience, or retaliation.
- Know the medical reason for CHA's decision to deny, delay, terminate or change a request for medical care.
- To ask for an appeal of a decision to deny, defer or limit services or benefit.
- Obtain free legal help at a local aid office or other groups.
- Get information about their medical condition and treatment plan options in a way that is easy to understand.
- Make suggestions to CalOptima Health about their member rights and responsibilities.
- Freely exercise these rights without retaliation or any adverse conduct by CalOptima Health and/or CalOptima Health affiliates including Subcontractors, Downstream Subcontractors, Network Providers, or the state.

CalOptima Health members are responsible for:

- Knowing, understanding, and following their member handbook.
- Understanding their medical needs and working with their health care providers to create their treatment plan.
- Following the treatment plan they agreed to with their health care providers.

- Telling CalOptima Health, CHA and their healthcare providers what we need to know about their medical condition so we can provide care.
- Making and keeping medical appointments and telling the office when they must cancel an appointment.
- Learning about their medical condition and what keeps them healthy.
- Taking part in health care programs that keep them healthy.
- Working with and being polite to the people who are partners in their health care.

E2: Member Benefits

Covered services are listed in the CalOptima Health Member Handbook. For more details, members can call CalOptima Health's Customer Service or go to their website: Benefits (caloptima.org)

E3: Member Grievances and Appeals

A **grievance**, or complaint, is when a Member has a problem or is unhappy with the services they received.

An **appeal** is a request to review a plan's decision made about a Member's services. Member can request the review of an adverse coverage decision on the health care services a Member believes they are entitled to receive, including the delay in providing, arranging for, or approving the health care services, or on the amount the member must pay for a service.

Members, or a Provider or authorized representative acting on behalf of the Member and with the Member's written consent, can submit a grievance or appeal by:

- Contacting CalOptima Health's Customer Service department
- Filling out a member grievance or appeal on CalOptima Health's website
- Visiting CalOptima Health's office at 505 City Parkway West, Orange, CA 92868
- Filling out a member complaint form and mailing it to CalOptima Health at:

  CalOptima Health
  Grievance and Appeals Resolution Services
  505 City Parkway West
  Orange, CA 92868

CalOptima Health will send the Member an acknowledgement letter within 5 calendar days after receipt of a grievance, indicating receipt of the grievance, the date of receipt of the grievance, and providing the name, telephone number, and address of the Resolution Specialist whom the Member may contact regarding the grievance, and provide the Member with an estimated completion date of resolution.

Any urgent or expedited matters that may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, will be reviewed by CalOptima Health within 72 hours of receipt. For all other grievances, the Member, or Provider or Authorized Representative, will receive a grievance resolution letter within 30 calendar days from the date of receipt.

CalOptima Health shall inform a Member of their right to request a State Fair Hearing after the Appeal process. A Medi-Cal Fair State Hearing is a meeting with CalOptima Health and a judge from the California Department of Social Services (DSS). The judge will help to resolve the member's problem or inform them that CalOptima Health made the correct decision. A Member can ask for a State Hearing only if they already filed an appeal with CalOptima Health and they are still not happy with the decision, or, if the Member did not receive a decision on their appeal after 30 days. The Member must ask for a State Hearing within 120 days from the date on the notice telling them of the appeal decision. Members can call the DSS Public Response Unit toll-free at (800) 952-5253. TDD/TTY users can call toll-free at (800) 952-8349. Member's may also fill out the form CalOptima Health provided with the Member's appeal resolution notice and mail it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 09-17-37
Sacramento, CA 94244-2430

SECTION F: MEMBER HEALTH EDUCATION PROGRAMS

F1: Referrals for Health and Wellness Services

Health and Wellness services are provided in all threshold languages at no cost by CalOptima Health Population Health Management (PHM). All eligible CalOptima Health Members are offered these benefits in person, telephonically, or in a group session. The goal is to assist and support the work of providers in promoting patient self-management and healthy behaviors while meeting established guidelines.

CalOptima Health's health and wellness topics include, but are not limited to:

- Asthma
- Cholesterol
- Chronic kidney disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Depression
- Fitness or exercise
- Heart disease
- High Blood Pressure
- Injury Prevention
- Preventive screenings
- Nutrition
- Pregnancy
- Tobacco cessation
- Weight control

CalOptima Health's Bright Steps program manages members who are pregnant and up to 12 months post-delivery. Members can receive services such as health coaching, nutrition education and assistance with resources. Pregnant members can self-refer into the program by calling (888) 587-8088, or providers can submit a Pregnancy Notification Report to CalOptima Health at any point during pregnancy.

Members diagnosed with diabetes, asthma, congestive heart failure, or chronic kidney disease are enrolled into the CalOptima Health Chronic Care Program. Newly identified members receive an introductory letter informing them of their eligibility to participate in the program, how to use program services, and instructions on how to opt out if they so choose.

CalOptima Health stratifies Chronic Care Program Members into two risk categories based on the severity of their condition and utilization characteristics. Based on their

risk level, the Member may receive educational mailings and/or be assigned to a health coach for telephonic outreach. The health coach makes outreach calls to Members and performs a comprehensive assessment, including a discussion regarding the importance of medication adherence. Based on the assessment, the health coach collaborates with the Member and their provider to develop a self-management Individualized Care Plan (ICP). In addition, each Member receives an educational mailing package on condition-specific information.

F2: 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.

Referring a Member

To refer a non-pregnant member, providers may complete a Health and Wellness Referral Form under the Common Forms link in the Providers section of the CalOptima Health website and fax it to: (714) 338-3127. Members can self-refer to any health and wellness service or program by calling CalOptima Customer Service at (888) 587-8088.

Opting Out of the 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 CalOptima Health Customer Service.

SECTION G: MEMBER MEDICAL RECORDS

G1: Medical Records Standards

Providers are required to have a medical record for each Member and to maintain procedures for storage, filing, retrieval, protection of confidentiality and release of information.

Each Provider site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

The Medical Records department manager or office manager shall be responsible for maintaining, monitoring and enforcing staff compliance in keeping member information confidential, and in the release of member information when requested by the Member, or under other conditions of release, in accordance with CalOptima Health policy, CalOptima Health HIPAA privacy policies, and applicable state and federal laws.

Active Records

A provider shall label and file all active records in a defined system to facilitate the retrieval of a record on demand. A provider shall store active records in a secured area that protects the records from loss, tampering, alteration or destruction.

Inactive Records

A provider may store inactive records in electronic or hard copy format in a secured area that protects the records from loss, tampering, alteration or destruction. A Provider shall retain inactive records for an adult and minor Members for ten years from the last date of service.

G2: Medical Record Content

Providers must meet the standards for medical record documentation in accordance with NCQA and state Medi-Cal Program Regulations. Providers shall establish an individual record for each Member and shall update the recording during each visit or encounter.

The record should be available in a legible, handwritten or typed format. The record shall reflect the findings of each visit or encounter. Any addendums to the records should be clearly identified, signed, and dated. The record should at a minimum include:

- Member name and additional identifiers such as date of birth or medical record number on each page
- Personal/biographical data in the record
- 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.
- All entries dated and author identified
- Problem list, past medical history, past surgical history, psychosocial history, family history, allergies, medications, immunizations, surgeries, procedures, and visits
- Prominently noted allergies and adverse reactions
- All informed consent documentation, including the human sterilization consent procedures, if applicable
- Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions
- Consultations, referrals, specialists, pathology and laboratory reports. Any abnormal results shall have an explicit notation of date, time, initials and action in the record
- 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
- Health education, behavioral assessment and referrals to health education services
- Documentation that Advance Directive information is offered

Every medical record shall be dated and signed by each staff person or provider at each encounter. The signature shall consist of at least the first initial, last name and title of the person making the entry, or, if signed electronically, with a date and time stamp.

Filing of Information

All reports shall be filed in the medical record within 48 hours after receipt, with physician signature and date of review including, but not limited to:

- Laboratory reports
- Imaging studies
- Electroencephalograms (EEGs) and Echocardiograms (EKGs)
- Physical therapy, occupational therapy and speech therapy reports
- Home health and hospice reports
- Consultation reports
- Hospital records (admission/outpatient procedures)
- Emergency Department records

Process for Missed Appointments or No-Shows

When a Member does not keep an appointment, the provider shall document the following in the Member's medical record:

- Date and time of missed appointment
- All attempts to reach the member
- Instructions given to the member when contact is made, advising the member of the need to obtain medically necessary care and the risks of not keeping the appointment

G3: Member Request for Medical Records

A Member shall have the right to inspect or copy his or her protected health information (PHI) in a designated record set, upon verbal request, unless the provider specifically requires a written request. Providers shall ensure Member access to their medical records. A provider shall not withhold a Member's medical records, or summaries of such records, due to unpaid bills for health care services. A Member, or Member's authorized representative, may obtain copies of all, or any portion of, the Member's medical records that the Member has a right to inspect upon presenting a written request for a copy of records.

SECTION H: CALOPTIMA HEALTH POLICIES AND PROCEDURES

H1: Overview

A complete library of CalOptima Health policies and procedures can be found on CalOptima Health's Compliance 360 website via the Resources Guide site.

Resource Guides (caloptima.org)

SECTION I: SERVICES COVERED BY CALOPTIMA HEALTH

I1: Behavioral Health Services

Outpatient Behavioral Health Services

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

- Outpatient psychotherapy (individual, family, and group therapy)
- Psychological testing to evaluate a mental health condition.
- Outpatient services that include lab work, drugs and supplies
- Outpatient services for the purposes of monitoring drug therapy
- Psychiatric consultation
- Screening, Assessment, Briefing Intervention and Referral to Treatment (SABIRT)

When members are determined to have a level of impairment other than mild to moderate, they will receive services directly from the Orange County Health Care Agency's (OC HCA) Mental Health, Crisis and Recovery Services (MHRS), or community-based organizations. MHRS 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 the long-term care (LTC) are eligible for behavioral health services covered by CalOptima Health. These services are for the treatment of mild to moderate behavioral health conditions. To assist a CalOptima Health member residing in an LTC facility access behavioral health services for mild to moderate conditions, the nursing facility can call CalOptima Health Behavioral Health. 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 Applied Behavioral Analysis (ABA) and other evidence-based services. A CalOptima Health Medi-Cal member may qualify for BHT services if the member:

- Is under 21 years of age.
- Meets medical necessity criteria.
- Has a recommendation from a licensed physician, surgeon, or 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.

How to Make a Behavioral Health Services Referral

To refer a CalOptima Health Medi-Cal member for outpatient behavioral health services, call CalOptima Health Behavioral Health and choose the Medi-Cal option. Members will be connected to a CalOptima Health representative. The member will be screened for level of impairment to determine appropriate services. Members will either be provided with referrals to CalOptima Health contracted behavioral health providers or directed to another level of care including MHRS.

To have a CalOptima Health 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.

I2: 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 Drug Medi-Cal Organized Delivery System (DMC-ODS) administered by the OC HCA.

DMC-ODS provides substance use disorder (SUD) treatment services to all eligible Medi-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 Health offers Alcohol and Drug Use Screening Assessment, Brief Interventions and Referral to Treatment (SABIRT) services by providers within their scope of practice to members 11 years and older, including pregnant women. Members under 21 years of age are eligible for additional screening benefits under EPSDT.

After determining whether 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.

How to Make a Referral to Alcohol and Drug Abuse Services

Both the member's PCP and behavioral health provider can make referrals to alcohol and drug abuse services. To receive member information related to substance abuse or behavioral health services covered by CalOptima Health, please contact CalOptima Health Behavioral Health. To access county DMC-ODS services, Medi-Cal members can call the county Beneficiary Access Line at (800) 723-2641, 24/7.

I3: Vision Services

CalOptima Health contracts with VSP Vision Care to provide vision services to all CalOptima Health Medi-Cal members. To refer a member to VSP for vision services, or for questions about coverage, please contact VSP.

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 who are under the age of 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.

I4: Perinatal Support Services

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

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

CalOptima Health relies on its providers to notify the Bright Steps program about pregnant women by submitting a Pregnancy Notification Report (PRN) form to CalOptima Health's PHM department within five calendar days after a member's first obstetric visit. Forms should be faxed to CalOptima Health's PHM department at (714) 246-8677. PSS is available to all pregnant members through the CalOptima Health Bright Steps program.

I5: Doula Services

Doulas are birth workers who provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriages, stillbirths and abortions. Doulas 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. Doula services can be provided virtually or in person with locations in any setting including, but not limited to, homes, office visits, hospitals or alternative birth centers.

Covered Services

- An initial recommendation for doula services includes the following authorizations:
  - One initial visit
  - Up to eight additional visits are 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
- 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.
- 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, and 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 works with the member's PCP or with CalOptima Health or CHA to refer the member to a provider who is able to render the service.

Non-Covered Services

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

- 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

I6: 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 promotors, community health representatives, navigators and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified by CalOptima Health. Through their community connection and engagement, CHWs will advance CalAIM efforts in providing equitable health care through culturally competent services.

Supervisor Provider

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

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. 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 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 or addressing health-related social needs.
- Screening and Assessment: Providing screening and assessment services that do not require a license and assisting a member with connecting to appropriate services to improve their health.
- Individual Support or Advocacy: Assisting a member in preventing the onset or exacerbation of a health condition or preventing injury or violence.

Non-Covered CHW Services

- Clinical case management/care management that requires a license
- Childcare
- Chore services, including shopping and cooking meals
- Companion services
- Employment services
- Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care

- Delivery of medication, medical equipment or medical supply
- Personal care services/homemaker services
- Respite care
- Services that duplicate another Medi-Cal service already being provided to a Member
- Socialization
- Coordinating and assisting with transportation
- Services provided to individuals not enrolled in Medi-Cal, except as noted above
- Services that require a license
- Peer support services

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

I7: Responsibilities for Indian Health Care Providers (IHCP) and American Indian Members

CalOptima Health is required to have an identified tribal liaison dedicated to working with each contracted and non-contracted 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.

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)
- An Indian Tribe, which has the meaning given in the IHCIA
- A Tribal Organization, which has the meaning given in the IHCIA
- An Urban Indian Organization (UIO), which has the meaning given in the IHCIA

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.

American Indian Member Rights and Protections

- American Indian Medi-Cal members are not required to enroll in an MCP, except in 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 PCP.
- 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 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 changes. 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, 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 IHS or Tribal FQHC 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 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.

- 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 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.
- CalOptima Health will reimburse an IHCP in accordance with the federal standard of payment, which includes payment of 90% of all clean claims 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 FQHCs, 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 FQHC Providers.
- Urban Indian Organizations, enrolled in Medi-Cal as a FQHC, are to be reimbursed through the Prospective Payment System 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 Health'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.

SECTION J: SERVICES COVERED BY MEDI-CAL AND OTHER AGENCIES

J1: Pharmacy Services

The Medi-Cal outpatient pharmacy benefit transitioned from CalOptima Health to Medi-Cal Fee-For-Service under a program called Medi-Cal Rx. DHCS is working with a contractor, Magellan Rx, to provide Medi-Cal Rx services. For more information on approved medications, pharmacy locations and member benefits, please visit the Medi-Cal Rx website Medi-Cal Rx | Homepage or contact Medi-Cal Rx Customer Service Center at (800) 977-2273.

J2: 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.

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.

Neither CalOptima Health nor CHA are responsible for the provision of payment of AIDS Waiver services.

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.

J3: 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 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.
- Member receiving services due to a condition that might complicate a pregnancy.
- Members receiving Federally Required Adult Dental Services (FRADS).

The current dental benefit is administered by the Medi-Cal Dental Program and not by CalOptima Health or CHA. CHA is 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.

How to Make a Referral for Dental Services

To make a referral to the Medi-Cal Dental Program, please call Medi-Cal Dental or go to the website.

All children with an active infection, pain or severe problems should be referred to the Medi-Cal Dental Program for immediate diagnosis and treatment by a dentist or oral health surgeon. Children with other dental problems should be referred within a reasonable period of time for diagnosis and treatment.

All children over the age of three should be referred to a dentist. Children over the age of three should have the benefit of definitive dental diagnosis, remedial treatment and should be seen by a dentist at least annually.

J4: 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.

Any resident of Orange County under the age of 18 who has or may have a developmental disability is entitled to receive an assessment to determine eligibility.

To be eligible for services, a person must have a disability that is substantially handicapping; examples include intellectual disability, epilepsy, cerebral palsy, autism, and disabling conditions found to be closely related to intellectual/cognitive disabling or that require treatment similar to that required for individuals with intellectual disabilities. The RCOC does not cover handicapping conditions that are solely psychiatric or a learning disability.

Those individuals diagnosed with developmental disability, according to law, become “consumers” of RCOC and can receive continuing services.

Coordination of Member Care

CalOptima Health or CHA shall designate a community liaison or case manager to serve as a liaison to RCOC to help coordinate care, as needed.

How to Make a Referral for RCOC

Providers who believe that a patient should be referred to the RCOC, should contact the RCOC offices. For more information, please visit RCOC’s website.

SECTION K: REQUIRED HEALTH ASSESSMENTS

K1: Initial Health Appointment (IHA)

The IHA is a comprehensive assessment completed during the Member's initial visit(s) with their selected or assigned PCP, including OB/GYNs and specialists for Members with special needs such as the SPD population. The purpose of the IHA is to assess and set the baseline for managing the acute, chronic, and preventive health needs of the Member.

All Members must receive an IHA within 120 calendar days of enrollment with CalOptima Health.

The IHA consists of a:

- 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
- Diagnoses, health education, and a plan for treatment of any disease

Exemptions from IHA Requirements

Selected members may be exempt from the IHA requirement under the following conditions:

- All elements of the IHA have been completed within less than 12 months of the Member's effective date of enrollment, and the PCP has reviewed, updated, and determined the Member's medical record contains complete information;
- The member has not been continuously enrolled in CalOptima Health during the 120 days;
- The member loses eligibility in less than 120 days prior to an IHA being performed;
- The member declines the IHA and refusal is documented in the Member's medical record;
- Three documented outreach attempts to schedule a member for an IHA visit within the first 120 days of enrollment; or
- The member misses a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful.

DHCS Requirements

Providers must complete preventive services on all Members as required by the AAP for members less than 21 years of age. Providers will follow the most recent anticipatory guidance as outlines in the current AAP Bright Futures periodicity schedule. PCPs must complete all age-specific assessments and services according to the United States Preventive Services Task Force.

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.

SECTION L: PEDIATRIC PREVENTIVE SERVICES

L1: Pediatric Preventive Services (PPS)

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 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.

In order to be eligible for payment, all providers who bill for PPS services must be contracted with CHA. School districts, public health care agencies, and laboratories can still bill for PPS services without a contractual relationship with CHA.

The CPE program provides immediate temporary, full-scope benefits on a Fee-For-Service basis for up to 60 days for those who qualify. Families should apply for health coverage programs and complete the application process to find a long-term health insurance program that fits their needs.

Participation Requirements

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

- Providers must be contracted with CHA.
- Providers must be registered with the 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 Health program.
- Providers must follow the AAP guidelines.
- 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.

Vaccines for Children (VFC) Program

The VFC Program provides vaccines to children whose parents or guardians may not be able to afford them. The program helps ensure that all children have a better chance of getting their recommended vaccinations on schedule and staying healthy. A child is eligible for the VFC Program if they are younger than 19 years of age and are one of the following: Uninsured, Medicaid-eligible or Medicaid-enrolled, American Indian or Alask Native, or Underinsured.

Providers do not have to be a Medicaid provider to participate in the VFC Program. Any healthcare provider (including pharmacists) authorized by their state law granting them the authority to administer vaccines by prescription, vaccine protocol, or prescribing authority can be a VFC Program provider. To enroll in the VFC Program:

- Contact your state/local/territory VFC Program coordinator to request enrollment.
- Complete and return the State Provider Enrollment forms
- Prepare for a site visit to go over the program's administrative requirements and proper storage and handling of vaccines once you have completed and returned the enrollment forms.

SECTION M: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT REFERRALS

M1: 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.

EPSDT services include medically necessary BHT for Medi-Cal eligible individuals less than 21 years of age. BHT includes, but is not limited to, ABA.

Services Provided Under EPSDT

EPSDT supplemental services include, but are not limited to:

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

Elements of EPSDT

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

Diagnostic: Performing diagnostic tests to follow up when a risk is identified

Treatment: Treating any problem found

M2: EPSDT Coverage

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.

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 service.

SECTION N: MODEL OF CARE

N1: Overview

The Model of Care programs address a special population of Members living with chronic illness, or developmental, physical, and/or cognitive challenges. Medi-Cal members are identified as eligible for these programs through an aid code(s) assignment by the DHCS or when determined by the county to have a CCS eligible condition.

N2: Program Services

CalOptima Health completes the initial outreach to the member to complete a Health Needs Assessment. Based on the assessment, CalOptima Health will identify the Member's care management level (Basic, Care Coordination, or Complex Case Management). Then CalOptima Health sends the case to CHA for assignment to a Patient Care Coordinator.

The Patient Care Coordinators are non-clinical associates who are dedicated to helping Members in our Care Management Program, Senior and Persons with Disabilities (SPD) Program, Whole Child Model (WCM) Program, Enhanced Care Management (ECM), and Community Supports. The Patient Care Coordinators work closely with health care providers, case managers, CalOptima Health, and agencies throughout Orange County to help guide members through the healthcare system. They help members obtain proper care, timely referral to services, and connect them with health and community resources. Patient Care Coordinators provide ongoing assistance to the member and member's family (i.e., "concierge" services).

When deemed applicable by CalOptima Health, a CHA Interdisciplinary Care Team (ICT) will facilitate an Individual Care Plan (ICP). The ICP is driven by parent concerns and medical recommendations. An ICP includes personalized goals and objectives, specific services and benefits, and measurable outcomes. Not every member, that is part of the Model of Care program, will have an ICP created.

CHA will hold ICT meetings based on the ICP. PCPs are encouraged to attend Interdisciplinary Care Team (ICT) meetings via phone or in-person when possible. Invitations to the ICT are sent to the PCP via fax. PCPs can have a representative attend on the PCP's behalf, such as a midlevel provider (Nurse Practitioner, Physician Assistant, Licensed Vocational Nurse). Parents/Guardians are also encouraged to attend ICT meetings via phone.

Once the ICT meeting has occurred, the ICPs are sent to the Member's assigned PCP, FQHC, or RHC for review, input, and acknowledgment. The PCP, FQHC, or RHC reviews the ICT's medical recommendations and provides any additional input within 72 hours of receipt. Per CalOptima Health's Health policy, the Member's assigned PCP, FQHC, or RHC are required to sign the ICP confirming that they acknowledge the Member's care plan. Once signed, the signed copy must be sent back to CHA.

SECTION O: CALIFORNIA CHILDREN'S SERVICES AND WHOLE CHILD MODEL

O1: Whole Child Model (WCM)

The WCM is a program that aims to help 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. The WCM integrates services traditionally covered separately by CCS and Medi-Cal into one health plan.

O2: CCS Services Provided Under the WCM Program

CCS is a Whole Child Program statewide program that determines medical eligibility, provides authorizations for medical care, case management, financial assistance, and medically necessary physical and occupational therapy services to children who meet the CCS eligibility criteria.

In Orange County, CalOptima Health and CHA are responsible for coordinating and authorizing CCS services consistent with its current processes. Both CCS and Medi-Cal services will be managed by CalOptima Health and CHA.

CCS services are provided by CCS-paneled and CCS-approved providers. If a specialist is not enrolled as a CCS provider, they can apply through the DHCS website at CCS Panel Application.

Prior to applying as a CCS provider, the provider's NPI number must be enrolled with Medi-Cal. Providers can find more information on how to become a CCS-paneled providers on the DHCS webpage at Becoming a CCS Provider.

The local CCS program will retain responsibility for determining CCS program eligibility. Note that CCS eligibility is separate from Medi-Cal eligibility.

To be eligible for CCS, CalOptima Health members must be diagnosed with a CCS-qualifying condition. For an overview of medically eligibly qualifying diagnoses, please visit the DHCS website or the County of Orange website.

DHCS website for CCS eligibility: Medical Eligibility

The County of Orange website: California Children's Services | Orange County

SECTION P: SPD PROGRAM

P1: What is the SPD Program?

The Seniors and Persons with Disabilities (SPD) program addresses a special population of members living with chronic illness, or developmental, physical, and/or cognitive challenges.

Our Care Management team works closely with health care providers and agencies throughout Orange County to help guide members through the health care system.

SECTION Q: CARE MANAGEMENT SERVICES

Q1: Care Management and Coordination

The Care Management Team at CHOC Health Alliance is comprised of Nurses, Social Workers, Physicians and Patient Care Coordinators who work to facilitate care coordination to our members and families. The team provides assessment, evaluation, planning, facilitation, and advocacy to promote the best possible outcomes for our members. Once the care management referral is received our staff assigns the Member to a level of case management services based on their specific needs and case complexity.

Q2: Referrals for Care Coordination and Care Management

Who qualifies for services?

Care Management is an "opt in" program available to any member or family struggling to cope with medical, social, or emotional challenges related to an acute or chronic illness. All CHA Members qualify, newborn to 21 years of age.

Referral Submissions

- **Fax or Email**: Fill out the Care Coordination/Care Management Request form and fax to (714) 628-9119 or email the form to CHACM@choc.org.
    - To access the request form, visit the CHA website at Provider Manual and Forms - CHOC Health Alliance
    - Include the Member's relevant clinical records along with the form

Q3: Contacting a Case Manager

Once a case is open, the referring provider will be notified by the assigned case manager. We encourage you to communicate with your member's case manager whenever necessary.

Q4: When is a Case Closed?

The case is closed once the Member either achieves their goals, loses eligibility, ages out of CHA, or stops participating.

SECTION R: LONG-TERM SERVICES AND SUPPORTS

R1: Overview

CalOptima Health administers the following Long-Term Support Services (LTSS):

- Long-term care (LTC) as a Medi-Cal managed care plan benefit
- 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
- 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

R2: Community-Based Adult Services (CBAS)

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: CBAS center, a member or member's authorized representative, a member's PCP or specialist, 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 CHA, CalOptima Health's LTSS staff shall process all CBAS benefit inquiries and CBAS authorizations 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 quality for CBAS, members must meet the following eligibility requirements for the CBAS program:

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

  Or one of the following:

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

CalOptima Health LTSS staff or 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 shall not require an initial F2F review when adequate documentation is available to make a determination that a member is eligible to receive CBAS. CalOptima Health LTSS clinical staff shall make CBAS eligibility and medical necessity determinations based on available clinical documentation. These include:

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

CBAS 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 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 fax to the CalOptima Health LTSS department:

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

CBAS Incident Report

The CBAS Incident Report shall be used by CBAS centers to provide summary information on adverse events that occur at or in transit to or from CBAS centers. CBAS centers shall report critical incidents to CalOptima Health using the CalOptima Health CBAS Incident Report. Report must be sent to CalOptima Health's QI department within 24 hours of the findings, along with supporting documentation of the reportable incident, to qualityofcare@caloptima.org or fax to (657) 900-1615

R3: 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 tasks related to the administration of the IHSS program.

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

R4: Contact Information

For more information from CalOptima Health for CBAS or IHSS services (initial referrals only), contact LTSS at (714) 246-8600.

In order to apply for IHSS, members may call Orange County 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 conduct a needs assessment.

SECTION S: ELECTRONIC VISIT VERIFICATION

S1: Electronic Visit Verification (EVV)

States are mandated 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. This includes, but is not limited to, PCS and HHCS delivered as part of CBAS, WCM, and Community Supports. 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.

All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:

- the type of service performed
- the individual receiving the service
- the date of service
- the location of service delivery
- the individual providing the service, and
- the time the service begins and ends

PCS 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.

Providers must complete the self-registration process to gain access to the California EVV (CalEVV) online portal. CalEVV is required for the following provider types:

- AIDS Waiver Services
- Employment Agency
- Home and Community Based Services (HCBS) Benefit Provider
- Home Health Agency
- Licensed Clinical Social Worker
- Licensed Vocational Nurse, Registered Nurse
- Multipurpose Senior Services Program (MSSP)
- Non-Profit Proprietary Agency
- Occupational Therapist

- Personal Care Agency
- Physical Therapist
- Professional Corporation
- Speech Therapist

The following services are not subject to EVV requirements:

- HHCS or PCS that do not require an in-home visit
- HHCS or PCS provided in congregate residential settings where 24-hour service is available
- HHCS or PCS that are provided by a “Live-in Caregiver," which may impact some Individual Nurse Provider (INP) or Private Duty Nursing (PDN)
- Services rendered through:
    - Program of All-Inclusive Care for the Elderly (PACE)
    - Hospice services
    - California Community Transitions (CCT) program
    - Genetically Handicapped Persons Program (GHPP)
    - Applied Behavioral Analysis (ABA)
    - Behavioral Health Treatment (BHT) or individuals with intellectual disabilities, or an institution for mental diseases
    - Doula Services
    - Community Health Workers (CHW)
    - Assisted Living Waiver (ALW)
- HHCS or PCS that are provided to inpatients or residents of a hospital, long term care includes but not limited to SNFs both freestanding and hospital-based SNFs, subacute facilities, pediatric subacute facilities, and intermediate care facilities
- In-home delivery and setup of Durable Medical Equipment (DME)
- Dual Eligible Plans or Medi-Medi plans for both HHCS and PCS that are primarily paid by Medicare and/or Other Health Coverage (OHC)
- Attendant care providers rendering services for medical transportation trips and appointments

For additional information, please visit the EVV website: EVV

SECTION T: REFERRALS AND AUTHORIZATIONS

T1: Services Requiring Prior Authorization

CHA performs utilization management functions, including referral authorizations, 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.

CHA conducts prospective review to evaluate referrals for specified services or procedures that require authorization. Authorization determinations made by licensed review nurses are based on medical necessity and appropriateness of care and reflect the application of approved review criteria and guidelines. Physician review and determination is required for all final denial or modified decisions for requested medical services. The denial of a physician-administered drug authorization may be reviewed by a qualified physician or pharmacist.

What is a prior authorization?

Services that require prior approval by CHA before those services are rendered.

If approved, the authorization stays active for a specified date range and may expire. For extension requests, complicated cases, or any questions, contact CHA Provider Services at (800) 387-1103.

What is a direct referral?

A member may be referred to another contracted CHA practitioner for certain services without prior authorization from CHA. Please refer to the CHA Quick Reference Guide to access the list of codes and services that does not require prior authorization from CHA.

Services requiring prior authorization

For the most up-to-date information, download the CHA Quick Reference Guide available on our website at Authorizations - CHOC Health Alliance.

Specialist Services	
• Hospital-based procedures & surgeries • Ophthalmology services/testing (excludes E&M)	• Podiatry services (including consults & E&M) • All office-based services (excludes E&M, diagnostic testing, minor surgical procedures)

Other Services	
• All Out of network providers (excludes ER and Family Planning services) • All Inpatient services (excludes ER and Family Planning services) • Acupuncture • Chiropractic Services • Developmental Screenings-Age 5 and up • Dialysis • Dr. Riba's Health Club • Durable Medical Equipment (DME) • Genetic Testing	• Hearing Aids/ Cochlear Implants • Home Health/Hospice/Palliative Care • Infusion Medications • Injectable drugs, including Chemotherapy, provided in an office or hospital setting • Medical and Incontinence supplies • Non-emergency medical transportation • Orthotics and Prosthetics • Surgical Procedures • Therapy services (Physical, Occupational, and Speech Therapy)

Services not requiring authorization

Certain Medi-Cal covered services do not require prior authorization, irrespective of whether the member seeking the service is enrolled with CHA.

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

To get a list of additional services that CHA does not require prior authorization for, please refer to the CHA Quick Reference Guide.

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.

T2: Requesting Prior Authorization

How to Submit Prior Authorizations

- Electronic Submission
  - Go to EZ-NET™ Login
  - Sign in to your EZ-NET account
  - Under the Auth/Referrals tab, click Auth Submission
  - Fill out each section, attach relevant medical records, and submit.
- Fax Submission
  - Visit CHOC Health Alliance to download and print the CHA Prior Authorization Form.
  - Fax the completed form to (855) 867-0868.

Prior Authorizations for CCS Services in the WCM

Prior authorizations for CCS services are the responsibility of CHA. CHA will process and approve authorizations for both CCS and Medi-Cal services. To simplify this process for providers:

- CHA created Condition-Specific Authorization Groups (CSAGS) for common CCS diagnoses.
- Providers are only required to submit a single authorization request for these medical diagnoses.
- CHA will follow existing prior authorization guidelines for all services, whether under CCS or Medi-Cal

Authorization Processing Time:

- Urgent Authorizations: within 72 hours
- Routine Authorizations: within 5 business days
- Retro-Authorizations: within 30 calendar days
- Physician Administered Drugs (PADs): within 24 hours

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

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

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

Authorization Denial and Reconsideration

Providers may request reconsideration of a denial by submitting a formal appeal to CHA. Contact CHA Provider Services for more information.

Peer-to-Peer Review

Providers may contact a physician reviewer to discuss adverse determinations. The name of the reviewing physician and contact information is included in the authorization denial or may be obtained by contacting CHA Provider Services.

T3: 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 CHA. CHA must review the request for medical necessity.

Referrals for second opinions should be directed to a provider who is contracted with CHA. Referrals to non-contracted providers or facilities will be approved only when the requested services are not available within the contracted network.

Second medical opinions can only be rendered by a physician qualified to review and treat the medical condition in question.

If the provider giving the second medical opinion recommends a particular treatment, diagnostic tests or services that is covered by Medi-Cal, is medically necessary, and in network, CHA will provide or arrange for services. If the second opinion recommends a particular treatment, diagnostic tests or services that is not covered by Medi-Cal and/or out of network, but considered medically necessary, CHA may provide or arrange for services. However, if the recommendations of the first and second practitioner differ regarding the need for a medical procedure or service, the member, authorized representative, or physician may request a third opinion.

SECTION U: CLAIMS AND BILLING

U1: Claim Submission Requirements

CHA Contracted Provider

Providers must submit claims and encounters to CHA for ALL services.

Medi-Cal Guidelines

Electronic and paper claims must follow Medi-Cal billing guidelines. For more information, visit Medi-Cal: Provider Home Page.

Timely Filing

File a claim on an electronic or paper form within **90 calendar days** of the date of service, unless otherwise specified by your contract. Failure to follow these guidelines may result in denial and nonpayment. Non-contracted providers are subject to Medi-Cal billing guidelines.

U2: Electronic Claim Submission

File claims and encounters electronically with one of our contracted vendors. To register for an account, contact Office Ally or Change Healthcare.

Vendor	Payer ID	Contact	Website
Office Ally	CHOC1	(866) 575-4120	www.officeally.com
Change Healthcare	33065 or SCH01	(866) 363-3361	www.changehealthcare.com

Please note that any claims, that include attachments, must be submitted via paper submission.

U3: Paper Claim Submission

If you must send a paper claim, mail it to the following address:

Via Mail:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims P.O. Box 1598 Orange, CA 92856
Via Physical Delivery:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims 5898 Copley Dr., Suite 307 San Diego, CA 92111

U4: Claim Status and Processing Time

Processing Time

The standard processing time for a claim is 30 calendar days from the date CHA receives the claim.

Status Updates

To check claim status:

- **Online**: Go to EZNet: EZ-NET™ Login
- **Phone**: Contact the Claims Department at (800) 387-1103, Option 1

U5: Claims for CCS in the Whole Child Model

Claim Requirements:

- Submit all claims to CHA for CCS services in the WCM
- Providers should only include CCS diagnosis codes on claims for CCS services
- Prior authorization numbers must be included on claims. CHA follows the DHCS payment methodology for CCS-paneled providers. It is the responsibility of the provider to notify CHA of their CCS paneled status at the time of contracting or if their CCS paneled status changes after initial contracting.

U6: Coordination of Benefits

When a member has other health coverage, CHA and CalOptima Health are the payers of last resort. Providers should coordinate benefits for covered services with other programs or entitlements, recognizing other health coverage as primary coverage.

Providers enrolled in Medi-Cal FFS or as a Medicare provider do NOT need to be contracted with CHA in order to see and bill for routine services for a patient who is dual-eligible or has OHC and is enrolled in CalOptima Health.

Billing CHA and Other Health Coverage (OHC):

- When requesting eligibility verification for a recipient with OHC, the CalOptima Health eligibility verification system returns a message stating a recipient's scope of coverage. If a recipient's eligibility shows an OHC code 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 CHA or CalOptima Health.
- The OHC benefit must be used completely. CHA may be billed for the balance, including OHC copayments, coinsurance, and deductibles. CHA will pay up to the Medi-Cal allowable amount, less the OHC payment amount, if any. CHA will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as a "payment in full."
- The amount, if any, paid by the OHC carrier for all items listed on the 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.
- When billing CHA for any service partially paid or denied by the recipient's OHC, the OHC EOB or denial letter must accompany the claim. 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. 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 benefit is not covered.

- 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.

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 co-payment or share of cost. Therefore, if the recipient's OHC requires a co-payment, coinsurance, deductible, or other cost sharing, the provider cannot bill the recipient. If the provider bills the OHC and the OHC denies or reduces payment because of its cost-sharing requirements, the provider may then bill CHA. CHA will adjudicate the claim, deducting any OHC payment amounts.

Exclusions

The following are not considered OHC:

- CalOptima Health managed care
    - 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.
- Automobile insurance
- Life insurance

Medicare coverage

Recipients who have CalOptima Health and Medicare HMO coverage must seek medical treatment through their Medicare HMO. CHA and CalOptima Health are not liable for payment for HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO. CalOptima Health claims for recipients with Medicare HMO coverage are not Medicare/CalOptima Health crossover claims. Therefore, to bill CHA or CalOptima Health for services not included in the Medicare HMO plan, submit a 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.

U7: Corrected Claims

A corrected claim is a resubmission of an existing claim. The corrected claim tells CHA that you are rebilling a previously submitted claim with the correct codes and/or modifiers, with the goal of payment.

Corrected Claim Submission Process

- Make the changes to the CPT, ICD-10, modifiers, etc. on a new paper form
- Stamp "corrected claim" on the document
- Mail the corrected claim to:

Via Mail:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims P.O. Box 1598 Orange, CA 92856
Via Physical Delivery:	Rady Children's Hospital – San Diego Attn: CHOC/CPN – Claims 5898 Copley Dr., Suite 307 San Diego, CA 92111

U8: Provider Complaint Process

CHA and CalOptima Health maintain a multi-level complaint process to review and resolve provider disputes for claims payment.

Provider Dispute Resolution (PDR)

A PDR is a provider's written request to CHA challenging or appealing a payment or denial of a claim. Disputes must be received within 365 calendar days from CHA's action that led to the dispute (or the most recent action if there are multiple actions).

- PDR Submission
    - Download the Provider Dispute Resolution request form at CHOC Health Alliance
    - Fill out the form and attach supporting documentation

- Mail the completed form and documents to:

  Via Mail: Rady Children's Hospital
  Attn: CHOC/CPN – Claims
  3020 Children's Way, Mail Code 5144
  San Diego, CA 92123

  Via Physical Delivery: Rady Children's Hospital – San Diego
  Attn: CHOC/CPN – Claims
  5898 Copley Dr., Suite 307
  San Diego, CA 92111

- Receipt, Review and Resolution
  - CHA will acknowledge receipt by mail within 15 business days. If you do not receive an acknowledgment letter, contact CHA Provider Services.
  - CHA then reviews the PDR request to determine whether to uphold or to overturn the initial decision.
  - Each provider dispute or amended dispute will be resolved in a written determination, stating the pertinent facts, and explaining the reasons for its determination, within 45 business days of receipt.

Second-Level Appeal

Providers who disagree with CHA's decision may file a second-level appeal with the CalOptima Health Grievance and Appeals Resolution Services (GARS). Providers must submit a request for review in writing within 180 calendar days of receiving a complaint resolution letter.

For additional resources on how to file a second-level appeal, visit Provider Complaint Process.

U9: Member Billing

Federal and state law **prohibits** providers from charging payment from Medi-Cal eligible members for covered services, or having any recourse against the Member. The prohibition on billing of the Member includes, but is not limited to:

- Covered services.
- Covered services provided during a period of retroactive eligibility.

- Covered services once the member meets his or her share of cost requirements.
- Copayments, coinsurance, deductibles or other cost sharing required under a Member's OHC.
- Pending, contested or disputed claims.
- Fees for missed, broken, canceled, or same day appointments.
- Fees for completing paperwork or forms related to the delivery of medical care, including but not limited to:
    - Immunization cards
    - Sports physical forms, or history of physical forms required by school.
    - Disability forms
    - Forms related to Medi-Cal eligibility.

Providers should not collect payment for services rendered in lieu of billing a claim to CalOptima Health, CHA, 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 should never ask a Member to inquire about the status of a claim.

Limited Circumstances in Which a Member may be Billed

A provider may bill a member only for services not covered by Medi-Cal, if:

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

SECTION V: PAYMENT

V1: Payment Disclaimer

Reimbursement for services is dependent on:

- Authorization of services, if applicable
- Member eligibility
- Medical necessity
- Provider's contract

V2: Payment Models

Capitation

Capitation is the fixed payment amount that a provider receives per-member-per-month (PMPM). It covers a defined scope of services (by procedure code) and varies based on a member's age and gender. Capitated services in CHA include:

- Most routine primary care services (e.g., sick visits)
- Most laboratory services (e.g., blood tests)

Fee-For-Service (FFS)

Fee-For-Service (FFS) is the payment amount that a provider receives for Medi-Cal covered services not included under capitation. Services paid FFS include:

- Certain "carve-out" primary care services (e.g., x-rays and minor surgical procedures)
- All services rendered to members with an SPD aid code.
- Services rendered by Specialists, Ancillary Providers, and Hospitals

CHA pays providers according to the current Medi-Cal fee schedule and Medi-Cal guidelines. For more information visit Medi-Cal Rates | Medi-Cal Providers.

V3: Payment Vendor:

ECHO Health/Change Healthcare

The easiest and quickest way to receive payment from CHA is to register with our contracted vendor and choose a preferred payment method. Please see details for registration below:

- Visit the Provider Payments Portal at www.providerpayments.com. This portal is available for all methods of payment and offers detailed payment information, such as the Explanation of Provider Payment (EPP).
- Call ECHO Health at (888) 834-3511. Be sure to select a method of payment for both capitation and fee-for-service.

V4: Payment Methods

Electronic Funds Transfer (EFT/ERA)

Payments transmitted directly from CHA to the provider's bank account.

- Single Payer: Receive payments through ECHO from one payer only (like CHA). There are no service fees associated with this set-up.
- All Payer: Receive payments through ECHO from multiple payers (like CHA and additional Health Networks). There is a 1.99% service fee associated with this set-up.

To enroll in EFT, providers can enroll online at ECHO Health

Virtual Card

Payments are issued on a one-time-use virtual visa debit transaction. Standard merchant fees may apply. To manage virtual card payments, providers can visit ECHO VCARD.

Paper Check

Payments are issued on a paper check and mailed to the provider's designated address.

V5: Refunds

In the event that CHA overpays a claim due to a payment or billing error, the provider can submit a refund to CHA. For any refunds, providers can mail a check to the CHA Finance department at the address listed below. Please include the member's name and date of birth associated with the refund payment, as well as a description of the reason for the refund.

Mail to:

CHOC Health Alliance
Attn: CHA Finance Department
1120 W La Veta Ave, Ste 450
Orange, CA 92868

V6: Support

Inquiry Type	**Contact**
CHA General questions	CHA Provider Services: (800) 387-1103
ECHO Customer Service/ General Payment Inquiries	ECHO Health Customer Service: (888) 834-3511
Virtual card	ECHO Health Card Services: (877) 705-4230

SECTION W: COMPLIANCE

W1: Medi-Cal Enrollment

The DHCS requires all CalOptima Health providers participating in Medi-Cal to enroll in the Medi-Cal program. This is a statewide requirement affecting all contracted CalOptima Health providers.

To enroll in the Medi-Cal program, please register through the DHCS site: Provider Enrollment Division (PED)

W2: Compliance Training Requirements

CalOptima Health requires all contracted providers and staff to complete annual training for the following areas:

- Fraud, Waste and Abuse
- Cultural Competency, including Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex and Asexual (LGBTQIA+) culturally competent training, as well as cultural and linguistic requirements
- Disability Awareness

To view additional compliance resources, such as CalOptima Health's Policies and Procedures or CalOptima Health's Code of Conduct, please visit CalOptima Health's compliance website: CalOptima Health's Commitment to Compliance.

For more information, visit CHOC Health Alliance or email providerrelations@choc.org.

W3: Fraud Waste and Abuse (FWA)

- **Fraud**: When someone knowingly and willfully execute, or attempt to execute, a scheme or artifice to defraud any health care benefit program or to obtain any of the money or property of any health care benefit program.
- **Waste**: Inefficiencies, directly or indirectly, that result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
- **Abuse**: When health care providers perform actions that directly or indirectly result in unnecessary costs to any health care program. Abuse involves paying for

items or services where there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

In summary, fraud requires intent to deceive, while waste and abuse implies no knowledge of intent or wrongdoing.

How To Report Suspected Health Care Fraud

Federal and state regulations require CalOptima Health and CHA to work with its providers to identify and report potential cases of health care fraud, waste, or abuse to law enforcement agencies. Please notify potential cases to CHA Compliance at chacompliance@choc.org.

Suspected fraud or abuse should also be reported to CalOptima Health immediately.

- 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 CalOptima Health Compliance and Ethics Hotline at (877) 837-4417. You may remain anonymous when calling the hotline.

CalOptima Health's Special Investigations Unit (SIU) will investigate cases to determine if potential fraud or abuse exists, refer potential fraud and abuse cases to the appropriate entity, and document the process for each case. CalOptima Health may coordinate an independent internal investigation with other CalOptima Health departments and First Tier, Downstream or Related Entity (FDR), 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.

W4: Cultural Competency

Cultural Competency is the state of being capable of functioning effectively in the context of cultural differences.

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 diverse populations without stigma or barriers.

Providers shall use culturally competent practices and provide 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

W5: Disability Awareness

Disability awareness education continues to be required for all staff and health care providers who care for CalOptima Health Members.

Impairment is an alteration of a person's health status as assessed by medical means. It's typically identified with an orange or body part. It ranges from mild to severe. It does not include impact on a person's ability to function in society.

Disability is a physical or mental impairment that substantially limits one or more of the major life activities (mobility, cognitive, vision, speech, or hearing). It can occur at birth or acquired over their lifetime. It can be visible or hidden.

Functional limitations are difficulties completing basic or complex activities because of a physical, mental, or emotional restriction. It may be due to behavioral and/or chronic health conditions.

Functional capabilities are strengths of a person with a disability to perform certain activities, with or without accommodations.

Accessibility requirements are intended to meet the needs of any patient to improve program access and health outcomes. Accommodations may include physical accessibility, changes to the provider office policies, accessible exam or medical equipment, effective communication, or member and health education materials in alternate formats.

SECTION X: HIPAA PRIVACY

X1: About HIPAA Privacy

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires CHA and its providers to protect the security and privacy of its Members' Protected Health Information (PHI) and to provide its Members with certain privacy rights, including the right to file a privacy complaint.

PHI is any individually identifiable health information, including demographic information. PHI includes a member's name, address, phone number, medical information, Social Security number, card identification number, date of birth, financial information, etc.

CHA supports the efforts of its providers to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment, CHA 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.

X2: 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.

If you would like 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 CHA member, whether caused by CalOptima Health, CHA, a delegated entity or an FDR, the provider should notify CHA and CalOptima Health immediately upon discovery. To report a breach to CHA, notify CHA Compliance at chacompliance@choc.org and CHOC Corporate Compliance by calling (877) 388-8588 or email compliancehotline@choc.org. To report a breach to CalOptima Health, call (888) 587-8088 and ask for the Privacy Officer, or email privacy@caloptima.org.

SECTION Y: QUALITY OF CARE ISSUES

Y1: Reporting Potential Quality of Care Issues

CalOptima Health monitors the quality of care provided to Members by its health networks and providers. As a part of this monitoring effort, CalOptima Health has a process for identifying and receiving reports of potential quality of care issues. CalOptima Health performs case reviews, investigate potential quality of care issues, and determine the severity of issues. Based on these investigations, CalOptima Health determines the appropriate follow-up action required for individual cases. CalOptima Health also aggregates potential quality of care issues data to help identify problems within the provider network.

What Constitutes as Potential Quality of Care Issues

Potential quality of care issues may include any of the following types of cases:

- A clinical issue or judgement that affects a member's care and has the potential for an adverse effect. This may include:
    - Delay in care or treatment, or delay in referral for testing or to a specialist that adversely affected the member's mental or physical health.
    - Unnecessary prolonged treatment, complications, or readmission
    - Failure to provide appropriate treatment that results in significantly diminished health status, impairment, disability, or death.
    - 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

Y2: How to Report a Potential Quality of Care Issue

The quality-of-care issue should be directed to:

CalOptima Health
Attention: Quality Improvement
505 City Parkway West
Orange, CA 92868
Or qualityofcare@caloptima.org

Or fax at (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 date(s) the incident occurred.

What Happens Once a Potential Quality of Care Issue Complaint is Filed

CalOptima Health will request that CHA gather documents, which may include medical records and the provider's response to the complaint. CalOptima Health shall conduct a case review of the requested information and evaluate the issue.

CalOptima Health's physician reviewer will determine if a quality-of-care issue has occurred. If a quality issue exists, CalOptima Health's Credentialing and Peer Review Subcommittee may request corrective action or recommend de-credentialing and 805 reporting to the appropriate state board which may lead to termination of the contract.

Will the Provider or Party Filing the Complaint Hear About Resolution?

The reporting provider will not be informed of the outcome of the complaint. Only those directly involved in the case will be knowledgeable of the outcome.

SECTION Z: ACCESS AND AVAILABILITY

Z1: Appointment Access Standards

Providers are responsible for being available during regular business hours and have coverage after-hours.

Emergency and Urgent Care Services

Type of Care	Standard
Emergency Services	Immediately, 24/7
Urgent Care Services	Available within 24 hours of request

Primary Care Services

Type of Care	Standard
Urgent Appointment	Available within 48 hours of request
Non-Urgent Primary Care	Available within 10 business days of request
Routine Physical Exams and Health Assessments	Available within 30 calendar days of request
Initial Health Appointment (IHA)	Available within 120 calendar days of CalOptima Health enrollment

Specialty and Ancillary Care

Type of Care	Standard
Urgent Appointments that DO NOT require prior Authorization	Available within 48 hours of request
Urgent Appointments that DO require prior Authorization	Available within 96 hours of request
Non-Urgent Specialty Care	Available within 15 business days of request
Non-Urgent Ancillary Services	Available within 15 business days of request
Appointment for follow-up routine care with a physician behavioral health care provider	Members have a follow-up visit with a physician behavioral health care provider within 30 calendar days of initial visit for a specific condition

Other Access Standards

Type of Care	Standard
In-office wait time for appts	Shall not exceed 45 minutes before a member is seen by a provider
Rescheduling Appointments	Appointments will be rescheduled in a manner appropriate to the member's health care needs and that ensures continuity of care is consistent with good professional practice

Z2: Telephone Access Standards

During Business Hours

Description	Standard
Telephone Triage	Telephone triage shall be available 24 hours a day, 7 days a week. Telephone triage or screening waiting time shall not exceed 30 minutes
Telephone calls to answer	Wait time for a member to reach a non-recorded voice with a representative shall not exceed 30 seconds
Telephone wait time during business hours	Wait time for a member to speak with a representative, who is knowledgeable and competent regarding the Member's questions and concerns, shall not exceed 10 minutes
Non-urgent and non-emergency messages during business hours	Practitioner shall return phone calls within 24 hours after the time of message
Urgent messages during business hours	Practitioner shall return the call within 30 minutes after the time of message
Emergency message during business hours	All members shall be referred to the nearest emergency room. Include the following "If you feel that this is an emergency, hang up and dial 911 or go to the nearest emergency room"

After Business Hours

Description	Standard
Telephone Access: After-hours access	A PCP or designee must be available 24/7 to respond to after-hours member calls or to a hospital emergency room practitioner
Emergency after-hours	If a live after-hours attendant answers, the attendant shall refer the Member to 911 emergency services or instruct the Member to go to the nearest emergency room. If recorded message answers, it shall include the following “If you feel that this is an emergency, hang up and dial 911 or go to the nearest emergency room”

Z3: Cultural and Linguistic Standards

Description	Standard
Oral Interpretation	Oral interpreter services shall be made available to a Member in person, upon the Member's request, or by telephone at key points of contact, 24/7
Written Translation	All written materials to members shall be available in threshold languages as determined by CalOptima Health
Alternative Forms of Communication	Informational and educational information for members in alterative formats will be available at no cost in the threshold languages in large print (no less than 20-point, Arial font), audio format, or braille upon request, or as needed within 21 business days of request or within a timely manner for the format requested
Telecommunications Device for the Deaf (TDD)	TDD or California Relay Services (CRS) and auxiliary aids shall be available to members with hearing, speech, or sight impairments at no cost.
Cultural Sensitivity	Practitioners and staff shall encourage members to express their spiritual beliefs and cultural practices, be familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these beliefs into treatment plans.

SECTION AA: HEDIS PERFORMANCE

AA1: What is HEDIS®?

HEDIS® is a set of standardized performance measures used by health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction

AA2: CHA and HEDIS® Performance

HEDIS® ensures we are offering quality preventive care and service to our members. By proactively managing patients' care, you can effectively monitor their health and identify issues that may arise with their care.

Results are used to measure performance, identify quality initiatives, and provide educational programs for providers and members. We work with our providers to continuously improve performance on HEDIS® scores. Contact PR to review your performance and find opportunities for improvement.

At times, other Quality measures will be measured and encouraged as promulgated by Federal, State, DHCS, CalOptima Health, or other Agencies.

For more information and resources, contact PR at providerrelations@choc.org or visit www.chochealthalliance.com.

AA3: COZEVA®

COZEVA is the operating system that CHA uses to aggregate and transform multiple data streams into a registry driven dashboard. Providers can use COZEVA to:

- View member information
- View HEDIS care gaps
- View and print opportunity lists.

To access COZEVA, providers can go to their website at https://corp.cozeva.com/

To request a user account for COZEVA, please contact Provider Relations at providerrelations@choc.org.

SECTION AB: CREDENTIALING

AB1: Initial Credentialing

Initial Credentialing

Prior to participating in the CHA network, providers must become credentialed and approved by the CHA Credentialing and Performance Committee. Physicians, midlevel providers (such as physician assistants and nurse practitioners), and ancillary providers are responsible for the completion of CHA's credentialing application along with all required attachments.

CHA will submit a credentialing packet to the provider. The provider must return the completed application, along with any additional requested materials, to CHA's Credentialing department.

Please note that the CHA Credentialing department does not accept CAQH applications.

Full Scope Facility Site Review

In conjunction with the credentialing process, CalOptima Health also conducts a facility site review (FSR), medical records review (MRR), and physical accessibility review survey (PARS) of all new primary care sites, as required by the DHCS. CalOptima Health conducts a full scope FSR every three years for each primary care site.

If the provider is a high-volume specialist, CalOptima Health staff will contact the provider to schedule a PARS.

AB2: Re-Credentialing

Re-credentialing occurs every 36 months after the initial approved credentialing date. A few months before the deadline, the provider will receive a pre-populated application from CHA's Credentialing department. The provider is required to:

- Complete the application and verify that the pre-populated information is correct.
- Send the application to CHA's Credentialing Department for review.

For any questions related to the credentialing process, the provider may email the CHA Credentialing department at chacredentialing@choc.org.