CHOC Health Alliance

CHA Provider Training

Jan 2025

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Medi-Cal

Website: www.medi-cal.ca.gov

Medi-Cal is California's Medicaid program for low-income families, children, seniors, and persons 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.

CalOptima Health

Website: www.caloptima.org

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.

CHOC Health Alliance (CHA)

Website: www.chochealthalliance.com

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.

Medi-Cal Programs

Covered Services

Overview

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

For more information about Medi-Cal covered services, please follow the link: Medi-Cal Providers

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

EPSDT supplemental services include, but are not limited to:

- Acupuncture
- Audiology
- 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

Initial Health Appointment (IHA)

What is the IHA?

All new Medi-Cal members must complete their comprehensive Initial Health Appointment (IHA) **within 120 days from enrollment into CalOptima Health**. The IHA can be completed by their selected or assigned PCP, including OB/GYNs and Specialists for members with special needs such as the SPD population. At a minimum, it must include:

- A comprehensive physical and mental status exam
- 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
- Diagnosis, health education, and a plan for treatment of any disease

IHA components can be completed over the course of multiple visits

Initial Health Appointment (IHA)

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 the 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

Individual Health Education Behavioral Assessment (IHEBA)

Requirement:

CalOptima Health requires providers to administer an IHEBA as part of an IHA. Providers should administer the IHEBA utilizing the Staying Healthy Assessment (SHA), or other tool approved by CalOptima Health and the Department of Health Care Services

What is the Staying Healthy Assessment?

The SHA consists of seven (7) age-specific questionnaires available on the DHCS website www.dhcs.ca.gov.

Effective January 1, 2023, CalOptima Health no longer requires the SHA.

The standard screening requirements for each age group are still in effect

- All Ages: Assessment of need for preventive screenings
- Age 21 and under: EPSDT screenings per American Academy of Pediatrics/Bright Futures periodicity schedule

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 https://medi-calrx.dhcs.ca.gov/home/ or contact Medi-Cal Rx Customer Service Center at (800) 977-2273.

Be aware there may be some exceptions in which medications are managed by another entity. For example, physician administered medications are the responsibility of CalOptima Health.

Electronic Visit Verification (EVV)

In California, the Medi-Cal Electronic Visit Verification (CalEVV) is a federally mandated telephone and computer-based application program that electronically verifies **in-home** service visits completed for Personal Care Services (PCS) and Home Health Care Services (HHCS).

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

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the services
- Time the service begins and ends

For additional information, please visit the DHCS website: EVV (ca.gov)

Electronic Visit Verification (EVV)

CalEVV is required for the following provider types:

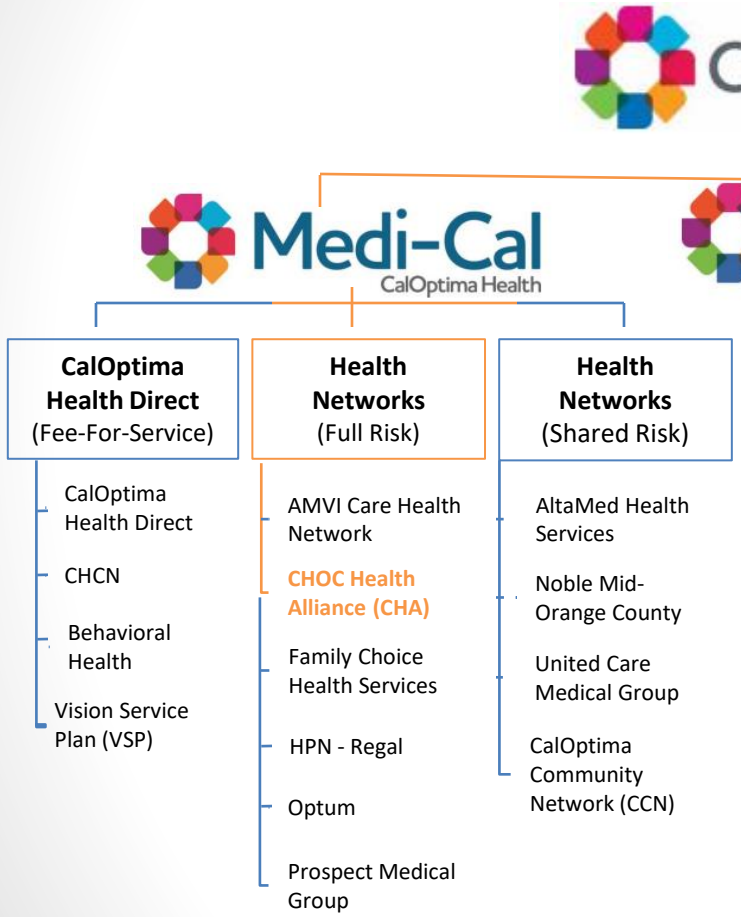
- AIDS Waiver Services
- Employment Agency
- Home and Community Based Services (HCBS) Benefit Provider
- Home Health Agency
- Licensed Clinical Social Worker
- Licensed Vocational Nurse, Registered Nurse
- Multipurpose Senior Services Program (MSSP)
- Non-Profit Proprietary Agency
- Occupational Therapist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

Providers who provide in-home services are required to register with CalEVV in the Provider Self-Registration portal: https://vendorregistration.calevv.com/

CalOptima Health Operations

CalOptima Health Programs

CalOptima Health Programs



Please Note: Each Health Network may have its own unique authorization, billing and service procedures.

While CHA is responsible for professional, facility, and ancillary services, some services may be authorized by CHA but the financial responsibility of CalOptima Health (such as Private Duty Nursing and Physician Administered Medications).

WCM & CCS

Whole Child Model (WCM)

The WCM is a program that aims to help children up to age 21 eligible for CCS and their families get better care coordination, access to care, and improved health results. Members who are CCS-eligible will have their CCS and Medi-Cal services managed by CalOptima Health and CHA.

California Children's Services (CCS) 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.

Eligible conditions include severe physical disabilities resulting from congenital defects or those acquired through disease, accident, or abnormal development. Examples include cerebral palsy, cystic fibrosis, cancer, heart conditions, and orthopedic disorders.

For more information on eligibility, visit the Orange County Health Agency's CCS website - www.ochealthinfo.com/phs/about/ccs.

Providers can apply to be CCS paneled through DHCS. Paneling instructions can be found at https://www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx

California Advancing and Innovating Medi-Cal (CalAIM)

Enhanced Care Management

Community Supports

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear initiative by the DHCS to improve the quality of life and health outcomes of the Medi-Cal population by extending services and supports beyond hospitals and health care settings directly into California communities.

The initiative leverages Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, including individuals experiencing homelessness, children with complex medical conditions, justice-involved populations who have significant clinical needs, and the growing aging population.

For additional information: California Advancing and Innovating Medi-Cal (CalAIM)

To refer members for ECM and/or Community Supports, referral forms can be found: Referral Forms

Enhanced Care Management (ECM)

DHCS will establish a new, statewide ECM benefit under the CalAIM initiative. ECM would provide a whole-person approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs.

Members will have a single lead care manager who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems.

ECM Includes:

- Comprehensive assessment and care management plan
- Care coordination and integrating services of cost-effective, quality direct health care services
- Connection to community resources for indirect care needs
- Improving health outcomes by addressing social determinants of health, such as environment, education and access to quality health care

Community Supports

Community Supports are services that helps address a member's health-related social needs and helps members live healthier lives. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay.

Community Supports can only be covered if:

- The state determines the service is a medically appropriate and cost-effective substitute or setting for the State Plan service
- The services are optional for the managed care plan to provide
- The services are optional for members, and they aren't required to use
- Services are authorized and identified in the state's Medi-Cal MCP contracts

For a list of community support services available, please go to the website: Community Supports (caloptima.org)

Long-Term Services and Supports

Long-Term Services and Supports

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 to LTSS? Members who:

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

Community-Based Adult Services

Community-Based Adult Services (CBAS) offers services to frail older adults or adults with disabilities, to restore or maintain their capacity for self-care and delay moving into an institutionalized setting.

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.

CalOptima Health's LTSS staff shall process all CBAS benefit inquiries and CBAS authorizations requests.

Reporting Requirements

Critical Incident Reporting
Fraud, Waste, and Abuse
Breach of PHI
Quality of Care Issues

Critical Incident Reporting

Community-Based Adult Services centers shall report critical incidents to CalOptima Health using the 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.

Critical Incidents:

- Mental anguish caused by willful use of offensive, abusive or demeaning language by caretaker
- Knowing, reckless or intentional acts of failures to act which cause injury or death to an individual, or which places that individual at risk of injury or death
- Rape or assault
- Corporal punishment or striking of an individual
- Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual
- Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations

Fraud, Waste, and Abuse

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.

How to Report Suspected Health Care Fraud

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

FWA Training: Fraud, Waste and Abuse (caloptima.org)

Additional Reporting

Breach of PHI

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.

CHA Compliance
Email:
chacompliance@choc.org

CHOC Corporate Compliance
Phone: (877) 388-8588
Email: compliancehotline@choc.org

CalOptima Health
Phone: (888) 587-8088
**Ask for the Privacy Officer*
Email: privacy@caloptima.org

Quality of Care Issues

To report a potential quality of care issue, the issue should be directed to CalOptima Health at:

Mail:
CalOptima Health
Attention: Quality Improvement
505 City Parkway West
Orange, CA 92868

or

Email:
qualityofcare@caloptima.org

or

Fax:
(657) 900-1615

Please include the member's name, CIN, provider's full name and address, and a description of the issue or concern including the date(s) the incident occurred.

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

Responsibilities for 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 payments for services provided to American Indian members who are qualified to receive services from an IHCP.

IHCP Rights and Protection

DHCS encourages Medi-Cal managed care plans (MCPs) to be proactive in developing processes designed to enhance collaboration with IHCPs and resolve IHCP inquiries within applicable authorization timeframes, including expedited authorizations.

Existing rights and protections for IHCPs, on the topics of enrollment, contracting, credentialing and site review, and claims payment, are described on the APL: APL 24-002

Definition of an “Indian”, “American Indian”, and “Tribal Health Program” can be located in the APL.

Responsibilities for IHCP and American Indian Members

American Indian Member Rights and Protections

- American Indian Medi-Cal Members are not required to enroll in an MCP, except in the case of COHS 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 Indians who disenroll from an MCP will receive services under the Fee-for-Service (FFS) delivery system.
- American Indian Members can request to receive services from an IHCP and can choose an IHCP within CalOptima Health's Network as a PCP. Additionally, American Indian Members may obtain Covered Services from an out-of-network IHCP without requiring a referral from a Network PCP or Prior Authorization. IHCPs, whether in the 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 receive services from an out-of-network IHCP even if there are in-network IHCP's available. American Indian members may request to receive services from an IHCP, and if there is no in-network IHCPs available, CalOptima Health will assist the member in locating and connecting with an out-of-network IHCP.
- American Indian Members are not subject to enrollment fees, premiums, deductibles, copayments, cost sharing, or other similar charges.

Behavioral Health Services

Behavioral Health Services

CalOptima Health is responsible for the outpatient behavioral health services for Medi-Cal members who have mild to moderate impairments resulting from a mental health condition. 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.

CalOptima Health Behavioral Health: (855) 877-3885

CalOptima Health directly manages the Medi-Cal behavioral health benefits. The member will be screened for level of impairment to determine appropriate services.

Behavioral Health Services

Behavioral Health Services at Long-Term Care Facilities

Medi-Cal beneficiaries receiving services under the LTC are eligible for behavioral health services covered by CalOptima Health. To assist a CalOptima Health member residing in a LTC facility access behavioral health services for mild to moderate conditions, the nursing facility can call CalOptima Health Behavioral Health.

Behavioral Health Treatment

CalOptima Health covers behavioral health treatment (BHT) services under EPSDT. BHT services include applied behavioral analysis (ABA) and other evidence-based services. A CalOptima Health Medi-Cal member may qualify 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

Dementia Care Aware Provider Training

The Dementia Care Aware program offers ways for providers and primary care teams to receive training on the cognitive health assessment and other relevant dementia care topics.

Dementia Care Aware has developed a compressive cognitive screening approach that providers can use quickly, confidently, and regularly with their older adult patients. This screening approach, is known as the cognitive health assessment and was developed with California's dementia and primary care experts. The assessment is a 5–10-minute annual screen that includes a cognitive screen, functional screen, and care partner assessment. The California DHCS recommends the assessment as standard of care for dementia screening for older adults.

Resources and training are available live, virtual, on-line, and via webinars.

Education & Training – DCA (dementiacareaware.org)

CalOptima Health Member Services

Member Handbook

Member Grievances and Appeals

Member Handbook

CalOptima Health Member Handbook - Member Documents (caloptima.org)

Member Benefits

Covered services are listed in the CalOptima Health Member Handbook. For more details, members can call CalOptima Health's Customer Service department at (714) 246-8500 or toll-free at (888) 587-8088 (TTY 711) or go to their website: Benefits (caloptima.org)

Member Rights and Responsibilities

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

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

Member Handbook

Member Rights and Responsibilities

Member rights includes, but are not limited to members taking the following actions:

- Voice complaints or appeals, either verbally or in writing, about CalOptima Health, CHA, provider or the care any provides. There is no time limit to file a compliant. CalOptima Health can assist with filing a complaint or grievance.
- Get oral interpretation services in the language that they understand at no-cost.
- 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.
- 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.
- Be free from any form of control, restraint, seclusion or limitation used as a means of coercion, discipline, pressure, punishment, convenience or retaliation

Please refer to the Member Handbook for a full list of Member's Rights and Responsibilities

Member Grievances and Appeals

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 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. Any of the below methods can be used to file a grievance towards a Network Provider and Out-of-Network Provider.

Members can submit a grievance or appeal by:

Contacting CalOptima Health's Customer Service department (714) 246-8500	Filling out a member grievance or appeal on CalOptima Health's website Reporting and Solving Problems	Visiting CalOptima Health's office at: 505 City Parkway West Orange, CA 92868	Fill out a member complaint form and mail it to: CalOptima Health Grievance and Appeals Resolution Services 505 City Parkway West Orange, CA 92868

CalOptima Health Provider Resources

Provider Resources on CalOptima Health's Website

Provider Communications

This includes the monthly provider newsletter, as well as Provider Updates based on recent Operating Instruction Letters received by the Department of Health Care Services

News and Events (caloptima.org)

CalOptima Health Policies & Procedures

A complete library of CalOptima Health policies and procedures can be found on their Compliance 360 site

Resource Guides (caloptima.org)

In the event of a conflict or inconsistency between the Provider Manual and other documents or laws, the following shall apply in the order of descending precedence: federal and state statutes; regulations and regulatory guidance; the provider contract; CalOptima Health policies and procedures; and the Provider Manual.

CHOC Health Alliance Operations

Provider Manual

The provider manual is a CHA administrative guide containing information to assist health care professionals with general information, policies and procedures to assist when providing healthcare to our members.

CHOC Health Alliance Website - [Provider Manual and Forms - CHOC Health Alliance]

Provider Access Standard Requirements

Appointment standards
Telephone standards
Cultural and Linguistic standards

Access Standards

Appointment Access Standards

Primary Care Services

Type of Care	Standard
Urgent Appointments	Available within 48 hours of request
Non-Urgent Primary Care	Available within 10 business days of request
Routine Physical Exams & 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

Access Standards

Appointment Access Standards

Emergency and Urgent Care Services

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

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

Telephone Access Standards: After Business Hours

Type of Care	Standard
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"

Access Standards

Telephone Access Standards: During Business Hours

Type of Care	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 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 & non-emergency messages during business hours	Practitioner shall return the call within 24 hours after the time of message
Urgent message 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"

Access Standards

Cultural and Linguistic Standards

Type of Care	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 shall be made 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 Competency Requirement

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

Cultural Competency Training (including Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex and Asexual (LGBTQIA+) cultural competency training) : Cultural Competency Training (caloptima.org)

Diversity, Equity, and Inclusion (DEI) APL: APL 24-016 (This APL supersedes APL 23-025)

Cultural Competency

Cultural and Linguistic Services

CHA offers free interpreter services to all limited English proficient members. CHA's services cover two areas:

- Interpreter services (telephonic and face-to-face interpretation)
- Translation services (materials available in threshold languages)

Using a family member or friend to interpret should be discouraged.

To schedule a service, please contact CHA's Provider Services at (800) 387-1103 and a team member will assist the office and member with creating an appointment.

Members may contact CHA's Member Services at (800) 424-2462 to schedule a service.

Member Information

Member Eligibility

Member Disenrollment

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, you may not receive payment for services provided on that date.

CalOptima Health member ID cards are used to help identify members and are NOT proof of member 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	Provider Portal: https://providers.caloptima.org
Medi-Cal	Website: www.medi-cal.ca.gov Phone (AEVS): (800) 456-2387

Member Disenrollment Request

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

1. 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
2. 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.

PROVIDER MUST NOTIFY THE MEMBER IN WRITING. Provider shall continue to be available for any urgent/emergency services for up to thirty (30) days, while the request is reviewed.

The Provider should submit to CHA the member's complete medical history with their request to disenroll, 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.

Authorizations

Authorization Process

CHA Provider Portal

Authorization Process

What information is required to submit a referral/prior authorization?

- Member Identification Number & Member's Date of Birth
- Referring Provider Information
- Referring To Provider Information (Rendering Service)
- Requestor's Contact Information
- Requested Procedures and Codes
- Diagnosis Codes
- Clinical Documentation supporting request
- Date of Service and Number of Units

Expected Turn Around Times

- Urgent=72 hours
- Routine=5 business days
- Retro=30 calendar days
- PADs=24 hours

Prior Authorizations /Referrals Dept.

- Phone: (800) 387-1103, Press 2
- Fax:(855) 867-0868
- Site: https://eznet.rchsd.org

Authorization Process

Prior Authorization Tips

- Check eligibility prior to providing services using one of the eligibility verification systems
- Check Authorization Quick Reference Guide*
  - If the service/code is listed as not requiring a prior authorization, do NOT submit an authorization request
- Verify Current Procedural Terminology (CPT) code on the Medi-Cal fee schedule before rendering services
- Attach supporting notes/documentation, if applicable
- Authorization status can be viewed in the EZ-Net portal

**A list of services approved for Direct Referrals and services that require Prior Authorization can be found at* Authorizations - CHOC Health Alliance

Authorization Appeals Process

Utilization Management Appeals and Provider Dispute Resolution Process

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

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.

Second Opinions

A member or the member's authorized representative may request a second medical opinion through their provider or by contacting CHA. 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 test or service that is covered by Medi-Cal, is medically necessary, and in network, CHA will provide or arrange for services. If it is not covered by Medical 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.

EZ-Net Provider Portal

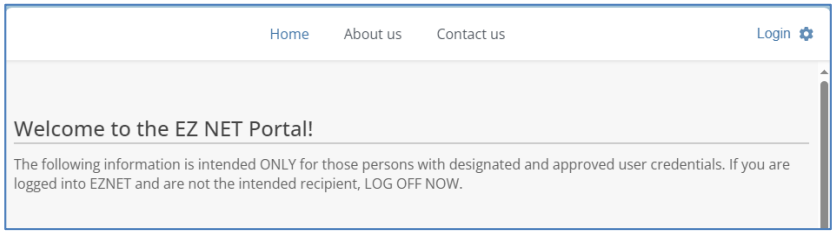
EZ-Net Services

https://eznet.rchsd.org

EZ-Net is CHA's secure provider portal.

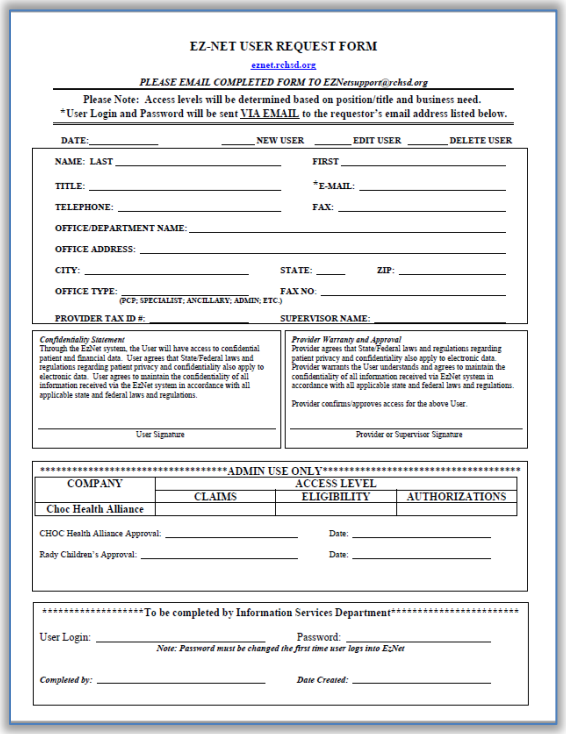
Use EZ-Net to:

- Verify member eligibility
- Submit authorizations
- Check authorization status
- View claim status



How to Access EZ-Net

- Fill out the User Request Form
- Email to EZNetsupport@rchsd.org
- Users will receive their username and temporary password to the email provided on the form
- Each user must have their own login and password



EZ-NET USER REQUEST FORM

eznet.rchsd.org

PLEASE EMAIL COMPLETED FORM TO EZNetsupport@rchsd.org

Please Note: Access levels will be determined based on position/title and business need.
*User Login and Password will be sent VIA EMAIL to the requestor's email address listed below.

DATE: _____ _____NEW USER _____EDIT USER _____DELETE USER

NAME: LAST _____ FIRST _____

TITLE: _____ *E-MAIL: _____

TELEPHONE: _____ FAX: _____

OFFICE/DEPARTMENT NAME: _____

OFFICE ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

OFFICE TYPE: _____ FAX NO: _____
(PCP; SPECIALIST; ANCILLARY; ADMIN; ETC.)

PROVIDER TAX ID #: _____ SUPERVISOR NAME: _____

Confidentiality Statement
Through the EzNet system, the User will have access to confidential patient and financial data. User agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. User agrees to maintain the confidentiality of all information received via the EzNet system in accordance with all applicable state and federal laws and regulations.

User Signature

Provider Warranty and Approval
Provider agrees that State/Federal laws and regulations regarding patient privacy and confidentiality also apply to electronic data. Provider warrants the User understands and agrees to maintain the confidentiality of all information received via EzNet system in accordance with all applicable state and federal laws and regulations.

Provider confirms/approves access for the above User.

Provider or Supervisor Signature

**********ADMIN USE ONLY**********

COMPANY	ACCESS LEVEL		
	CLAIMS	ELIGIBILITY	AUTHORIZATIONS
Choc Health Alliance			

CHOC Health Alliance Approval: _____ Date: _____

Rady Children's Approval: _____ Date: _____

**********To be completed by Information Services Department**********

User Login: _____ Password: _____
Note: Password must be changed the first time user logs into EzNet

Completed by: _____ *Date Created:* _____

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

Clinical Programs

Model of Care
Care Management
UM Workplan

Model of Care Programs

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 DHCS or when determined by the county to have a CCS eligible condition.

Includes: Senior and Persons with Disabilities (SPD), Whole Child Model (WCM), CalAIM Enhanced Care Management (ECM), and CalAIM Community Supports

Program Services

- CalOptima Health completes initial outreach to the member and sends the case to CHA for assignment to a (PCC).
- Patient Care Coordinator (PCC)
  - PCCs provide ongoing assistance to the member and member's family (i.e. "concierge" services).
  - PCCs are non-clinical associates.
  - PCCs are the main point of contract for members enrolled in the program. They are the liaison between the member, provider, CHA, and CalOptima Health.

Model of Care Programs

Program Services continued

- Individual Care Plan (ICP)
  - When deemed applicable by CalOptima Health, an ICP, driven by parent concerns and medical recommendations, is facilitated by a CHA Team.
  - An ICP includes personalized goals and objectives, specific services and benefits, and measurable outcomes.
  - NOTE: Not every eligible member will have an ICP created
- Interdisciplinary Care Team (ICT)
  - When deemed applicable by CalOptima Health, CHA holds ICT meetings based on the ICP.
  - Parents/Guardians and PCPs are encouraged to attend ICT meetings via phone.
  - PCPs can have a representative attend on their behalf (i.e. NP, PA, LVN).
  - Invitations to the ICT will be sent to the PCP via fax.

ICPs are sent to each member's PCP for review, input, and acknowledgement of member's care plan

CHA staff will assign the member to a level of case management services based on their specific needs and case complexity.

Seniors and Persons with Disabilities (SPD)

What is the SPD Program?

The SPD program is intended to help the below members access health care services

- Seniors
- Members with disabilities or chronic conditions
- Members without housing

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

Disability Awareness Training: Disability Awareness (caloptima.org)

SPD Resources: Seniors and Persons with Disabilities (caloptima.org)

Diversity, Equity, and Inclusion (DEI) APL : APL 24-016

Care Management

Additional members who do not fall under WCM, SPD or ECM can also be referred to our Care Management team. Any member or family struggling to cope with medical, social, or emotional challenges related to an acute or chronic illness can be referred.

Referral Submissions

Fill out the Care Coordination/Care Management Request form and fax it 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
- Include the member's relevant medical records along with the form

Connecting with a Case Manager

Once a case is open, the referring provider will be notified by the assigned case manager. CHA staff will assign the member to a level of case management services based on their specific needs and case complexity.

When is a Case Closed?

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

Utilization Management Workplan

The Utilization Management (UM) workplan is evaluated by:

- Measurable goals and health outcome measurements
- Evaluate quality of health care delivered to members
- Utilization management measures
- Disease management measures
- Ongoing performance improvement evaluation

CHA uses clinical protocols, evidence-based practices, and specific levels of quality outcomes in their review during the annual UM workplan and annual UM evaluation

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.

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

Claims

Billing Procedures
Complaint/Dispute Process
Member Billing Restrictions

Claim Billing Procedures

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

Electronic Claim Submission

Submit claims/encounters electronically via one of our contracted clearinghouses

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

Paper Claim Submission

If you must send a paper claim, send 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

All claims that have attachments must be submitted via paper submissions

Electronic and paper claims must follow Medi-Cal billing guidelines. For more information, visit www.medi-cal.ca.gov.

Claim Billing Procedures

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.)

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 at https://eznet.rchsd.org/

Phone: Contact the Claims Department at (800) 387-1103, Option 1

Claim Billing Procedures

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

Make the changes to the CPT, ICD-10, modifiers, etc. on a new paper form

Stamp “corrected claim” on the document

Send 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

Claim Billing Procedures

Coordination of Benefits (COB)

When a member has other health coverage (OHC), 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.

Billing CHA and other Health Coverage:

1. File claim with the primary insurer. The OHC benefit must be used completely.
2. If the primary insurer issues a partial payment or denial, CHA may be billed for the balance.
    a) 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. 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.
    b) 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.
3. If appropriate, 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."

Provider Complaint Process

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 PDR Request Form at Provider Manual and Forms
- Fill out the form and attach supporting documentation
- Send the completed form and documents to:

Via Mail:
Rady Children's Hospital – San Diego
Attn: CHOC /CPN Claims
3020 Children's Way, MC 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

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. Providers must submit a request for review in writing within 180 calendar days of receiving a complaint resolution letter.

Member Billing Restrictions

Billing Members for Covered Services is Prohibited

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 requirement
- Co-payments, coinsurance, deductible or other cost sharing required under a member's other health coverage
- Pending, contested or disputed claims
- Fees for missed, broken, canceled or same-day appointments
- Fees for completing paperwork related to the delivery of care (e.g. immunization cards, disability forms, sports physical forms, forms related to Medi-Cal eligibility etc.)

Member Billing Restrictions

Limited Circumstances in which the Member may be billed

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

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

Provider Payments Portal

ECHO Health

ECHO Health is a leading provider of electronic solutions for payments to healthcare providers. ECHO consolidates individual provider and vendor payments into a single ERISA- and HIPAA-compliant format, remits electronic payments, and provides explanation of provider payment details to Providers.

- Receive payment electronically
- Pull EOB/EOP reports
- Pull capitation reports

ECHO Health

ECHO Provider Payments Portal: ECHO Provider Direct - Login (providerpayments.com)

Claims and Capitation Payments are completed by ECHO and can be reimbursed as:

- Paper check
- Virtual Card (Vcard) – virtual visa debit transaction
  - Default option for new providers
  - To manage Virtual Card payments or change payment method, providers can update via ECHO VCARD (echovcards.com)
  - For Vcard specific inquiries, you may call (877) 705-4230
- EFT/ACH – automatic direct deposit to a bank account
  - To enroll in EFT, providers can enroll online ECHO Health (echohealthinc.com)
  - Providers can also email EDI@echohealthinc.com

You may contact the ECHO Customer Service for General Payment Inquiries at (888) 834-3511.

Quality Improvement (HEDIS)

Quality Improvement (HEDIS)

What is HEDIS®?

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

- Quality of care
- Access to care
- Member satisfaction

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Why is HEDIS Important?

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.

We work with our providers to continuously improve performance on HEDIS scores. Contact PR to review your performance and find opportunities for improvement.

For more information and resources, contact PR at providerrelations@choc.org. HEDIS Tools - CHOC Health Alliance

Applied Research Works

COZEVA®

Managing your HEDIS® Data in Real-Time

What is COZEVA®?

- NCQA (National Committee for Quality Assurance) HEDIS® certified platform for Pay for Performance
- Cozeva is the operating system that aggregates and transforms multiple data steams into a registry driven dashboard.
- Cozeva portal https://corp.cozeva.com/

How can COZEVA® help me?

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

For Cozeva training and access please contact providerrelations@choc.org

Quality Improvement Workplan

The Quality Improvement (QI) workplan is evaluated by:

- Measurable goals and health outcome measurements
- Measuring member experience of care
- Ongoing performance improvement evaluation
- Dissemination of quality performance

CHA uses standardized QI measures performance and health outcomes such as:

- Healthcare effectiveness Data and Information Set (HEDIS)
- Disease management measures
- Utilization management measures
- Member satisfaction surveys
- Provider satisfaction surveys
- Ongoing monitoring of complaints and grievance summaries

CHOC Health Alliance Contacts

CHOC Health Alliance Contact List

Resources	Contact Information
Provider Services (M-F 8am-5pm)	(800) 387-1103
Claims Department	(800) 387-1103, Option 1
Claim and Payment Appeals Provider Dispute Resolution (PDR)	(800) 387-1103, Option 1
Prior Authorization Department	(800) 387-1103, Option 2
Interpreter Services	(800) 424-2462 (Member line) (800) 387-1103 (Provider line)
Member Services (Available 24/7)	(800) 424-2462
Member Services Hearing Impaired TTY / TDD	(800) 735-2922 English (800) 855-3000 Spanish
CHOC Health Alliance Admin Office	(714) 565-5100
Provider Portal (EZ-NET)	https://eznet.rchsd.org
Website	www.chochealthalliance.com

Provider Relations Contact List

Provider Relations Department
ProviderRelations@choc.org

Elizabeth Kellam
Senior Provider Relations Representative
South Orange County
(714) 509-7166
Elizabeth.Kellam@choc.org

Caroline Cruz
Senior Provider Relations Representative
Central Orange County
(714) 509-7027
Caroline.Cruz@choc.org

Timothy Timbol
Senior Provider Relations Representative
North Orange County
(714) 509-7027
Timothy.Timbol@choc.org