



CHA Provider Training

Table of Contents

Section A: Medi-Cal & State Programs

- [Covered Services](#)
- [Early and Periodic Screening, Diagnosis and Treatment \(EPSDT\) Services](#)
- [Seniors and Persons with Disabilities \(SPD\)](#)
- [Whole Child Model \(WCM\) & California Children's Services \(CCS\) Program](#)
- [Pharmacy Services](#)
- [Electronic Visit Verification](#)

Table of Contents

Section B: CalOptima Health Operations

- [CalOptima Health Programs & Provider Resources](#)
- [CalOptima Health Member Services](#)
 - Member Handbook
 - Member Grievances and Appeals
- [Individual Health Appointment \(IHA\) & Individual Health Education Behavioral Assessment \(IHEBA\)](#)
- [Responsibilities for Indian Health Care Providers and American Indian Members](#)
- [California Advancing and Innovating Medi-Cal \(CalAIM\)](#)
 - Enhanced Care Management (ECM)
 - Community Supports
- [Behavioral Health Services](#)
 - Dementia Care Aware
- [Long-Term Support Services](#)
 - Community-Based Adult Services
- [Reporting Requirements](#)
 - Critical Incident Reporting
 - Fraud, Waste, and Abuse (FWA)
 - Breach of Protected Health Information (PHI)
 - Quality of Care Issues

Table of Contents

Section C: CHOC Health Alliance Operations

- [Provider Manual](#)
- [Member Information](#)
 - Member Eligibility
 - Member Disenrollment Request
- [Authorizations](#)
 - Authorization Process
 - EZ-Net Provider Portal
 - Authorization Appeals Process
- [Doula Services](#)
- [Clinical Programs](#)
 - Model of Care Program
 - Care Management
 - UM Workplan
- [Claims](#)
 - Billing Procedures
 - Provider Complaint/Dispute Process
 - Member Billing Restrictions
- [Provider Payments Portal](#)
 - ECHO Health
- [Provider Access Standards Requirements](#)
 - Appointment Standards
 - Telephone Standards
 - Cultural and Linguistic Standards
- [Cultural Competency Requirement](#)
- [Quality Improvement \(HEDIS\)](#)
 - Cozeva

Medi-Cal

Website: www.medi-cal.ca.gov

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.

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 Rady Children's Health 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 our Health Network when care is needed.

Medi-Cal & State Programs

Covered Services

Overview

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

For more information about Medi-Cal covered services, please follow the link: [Medi-Cal Providers](#)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

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
- Behavioral Health Treatment
- 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

Seniors and Persons with Disabilities (SPD)

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

- Seniors (aged 60 and older)
- Members with disabilities or chronic conditions

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](#)

SPD Resources: [Provider Training | SPD Resources](#)

WCM & CCS

Whole Child Model (WCM)

The WCM program helps children, up to age 21 eligible for CCS, and their families get better care coordination, access to care, and improved health results. Both CCS and Medi-Cal services will be 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 OCHA's CCS website: [OC Health Care Agency | About CCS](#)

Providers can apply to be CCS paneled. Paneling instructions can be found at [CCS Provider Enroll](#)

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 financial responsibility of CalOptima Health.

Electronic Visit Verification (EVV)

In California, the Medi-Cal Electronic Visit Verification (CalEVV) is a 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).

EVV must verify 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, and to see a list of Provider Types that are impacted, please visit the DHCS website: [EVV](#)

Providers who provide in-home services are required to register with CalEVV in the Provider Self-Registration portal: [California Provider Self-Registration Portal](#)

CalOptima Health Operations

CalOptima Health Programs



CalOptima Health Direct
(Fee-For-Service)

- CalOptima Health Direct
- CalOptima Health Community Network (CHCN)
- Behavioral Health
- Vision Service Plan (VSP)

Health Networks
(Full Risk)

- AltaMed Health Services
- AMVI Care Health Network
- CHOC Health Alliance
- Family Choice Health Services
- HPN-Regal
- Optum
- Prospect Medical Group

Health Networks
(Shared Risk)

- Noble Mid-Orange County
- United Care Medical Group

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

While CHA is Full Risk and 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).

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

[Provider Updates and Newsletters](#)

CalOptima Health Policies & Procedures

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

[Manuals, Policies, and Guides](#)

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.

CalOptima Health Member Services



Member Handbook

Member Grievances and Appeals

Member Handbook

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: [CalOptima Health Medi-Cal Benefits and Services](#)

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.

CalOptima Health Member Handbook: [Getting Started With Medi-Cal Insurance | CalOptima Health](#) (located under Member Documents and Forms)

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, Providers, or the care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination.
- Get oral interpretation services in the language that they understand at no-cost.
- Ask for a State Hearing, including information on the conditions under which a State Hearing can be expedited.
- Receive written member information at no cost in Braille, large-size or other formats upon request and in a timely manner appropriate for the format being requested.
- Be free from any form of control or limitation used as a means of pressure, punishment, convenience or revenge

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 CalOptima Health, a Provider, or with the health care or treatment they received. There is no time limit to file a complaint.

An **appeal** is a request to review and change a plan's decision about a Member's services. An appeal must be requested within 60 days from the date of the notice of action.

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 at (714) 246-8500

Filling out a member grievance or appeal on CalOptima Health's website:
[Your Rights | CalOptima Health](#)

Fill out a member complaint form and mail it to:
CalOptima Health
Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

IHA & IHEBA Assessments



Initial Health Appointment

Individual Health Education Behavioral
Assessment

Initial Health Appointment (IHA)

The IHA is a comprehensive assessment completed during the member's first visit with their selected or assigned PCP, including OB/GYNs and Specialists for members with special needs such as the SPD population. All members must receive an IHA within 120 calendar days of enrollment with CalOptima Health.

The IHA must include:

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

The IHA can be administered over the course of multiple visits, provided that all required components are completed within 120 days.

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 initial 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

Members with unsuccessful IHA completions require a minimum of three documented outreach attempts. Examples may include a phone call, letter, or postcard.

Individual Health Education Behavioral Assessment (IHEBA)

Requirement:

An IHEBA can be administered as part of an IHA. Providers should administer the IHEBA utilizing the Staying Healthy Assessment (SHA), or other tool approved by the Department of Health Care Services.

What is the Staying Healthy Assessment:

The SHA consist of age-specific questionnaires available on the DHCS website:

[Staying Healthy Assessment Questionnaires](#)

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

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. Currently, CalOptima Health does not have any IHCPs within CalOptima Health's service area of Orange County.

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.

- ❖ Overview of Trauma-Informed Care and Historical Trauma Guidance Training: [Trauma Informed Care | IHS](#)
- ❖ Cultural Humility Training: [From Cultural Humility to Cultural Safety | HIS](#)
- ❖ Also review any other relevant trainings as they are developed and noted by DHCS [Webinar Archives](#)

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 Indian Members can request to receive services from an IHCP and can choose an IHCP within 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 network or out-of-network, can provide referrals directly to Network Providers without a referral from a Network PCP or Prior Authorization.
- American Indian members may request to receive services from an IHCP, if there is no in-network IHCP available, CalOptima Health will assist the member in locating and connecting with an out-of-network IHCP.
- American Indian Members are not subject to enrollment fees, premiums, deductibles, copayments, cost sharing, or other similar charges.

California Advancing and Innovating Medi-Cal (CalAIM)



Enhanced Care Management

Community Supports

California Advancing and Innovating Medi-Cal (CaAIM)

CaAIM 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 \(CaAIM\)](#)

To refer members for ECM and/or Community Supports, referral forms can be found on the CaAIM page

Enhanced Care Management (ECM)

ECM is a statewide Medi-Cal benefit available to select populations of focus that addresses the clinical and non-clinical needs of members, with the most complex medical and social needs, through the coordination of health and health-related services.

ECM meets members wherever they are – on the street, in a shelter, in their doctor's office or at home.

Members will have a single lead care manager who will coordinate care and services among the physical, behavioral, dental, developmental, and social services delivery systems. The member's ECM provider works with all their providers to give an added layer of support.

ECM Offers:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning: develop an individualized care plan
- Enhanced Coordination of Care
- Health Promotion: Member is coached on how to better monitor and manager their health
- Comprehensive Transitional Care: such as transitions between the ER, Hospital, Residential Facility, SNF, etc.
- Member and Family Supports: Education to family, providing copies of care plan to family, sharing resources
- Coordination of and Referral to Community and Social Supports

ECM is exclusively for Medi-Cal managed care health plan members. Only managed care health plan members can access the ECM benefit.

Community Supports

Community Supports are services that help address a member's health-related social needs and help 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. Each Community Support service has a unique set of eligibility criteria.

For a list of community support services available, please go to the website: [California Advancing and Innovating Medi-Cal \(CalAIM\)](#)

Behavioral Health Services

Behavioral Health Services

Dementia Care Aware Provider Training

Behavioral Health Services

CalOptima Health is responsible for the outpatient behavioral health services, including Non-Specialty Mental Health Services, for Medi-Cal members who have mild to moderate impairments. 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)
- Transcranial magnetic stimulation (TMS)
- Dyadic services for children under 21 and their parents or caregivers

When members are determined to have a level of impairment other than mild to moderate, they will receive services directly from the Orange County Health Care Agency's (OC HCA) Behavioral Health Services (BHS), the county behavioral health agency, or community-based organizations. The BHS retains the responsibility for specialty mental health services, which include psychiatric inpatient hospital services.

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

CalOptima Health Behavioral Health: (855) 877-3885

Behavioral Health Services at Long-Term Care Facilities (LTC)

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 in accessing behavioral health services for mild to moderate conditions, the nursing facility can call CalOptima Health Behavioral Health.

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 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 \(dementiacareaware.org\)](https://dementiacareaware.org)

Long-Term Services and Supports

Long-Term Services and Supports

Community-Based Adult Services

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 low-income, elderly or disabled individuals. Participating seniors and disabled individuals receive services at a local community adult day care center, allowing participants to continue living at home, with the intention to minimize the need for placement in nursing homes.

CalOptima Health is responsible for determining CBAS eligibility and medical necessity criteria. In order to qualify for CBAS, Members must meet the following eligibility requirements:

- 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

Reporting Requirements



Critical Incident Reporting

Fraud, Waste, and Abuse

Breach of PHI

Quality of Care Issues

Critical Incident Reporting

A Nursing Facility or Community-Based Adult Services center 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

CBAS Incident Report Form can be found: [LTSS Common Forms](#)

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 link below.
- 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 (855) 507-1805. You may remain anonymous when calling the hotline

FWA Training is located on the following CalOptima Health website: [Preventing Health Care Fraud](#)

Additional Reporting

Breach of Protected Health Information (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 To:

CalOptima Health

Attention: Quality Improvement

505 City Parkway West

Orange, CA 92868

Email:

qualityofcare@caloptima.org

Fax:

(657) 900-1615

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

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.

[Provider Manual and Forms - CHOC Health Alliance](#)

Member Information



BACK TO TOP

Member Eligibility

Member Disenrollment Request

Member Eligibility

Except for emergency services, Providers must verify a member's eligibility 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:

<u>Eligibility Verification Systems</u>	
CHOC Health Alliance	Provider Portal (EZ-NET): https://eznet.rchsd.org Phone: (800) 387-1103
CalOptima Health	Provider Portal: https://providers.caloptima.org
Medi-Cal	Medi-Cal Provider Portal: 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

EZ-Net Provider Portal

Authorization Appeals Process

Authorization Process

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

- Member Identification Number & Member's Date of Birth
- Referring Provider Information (Must be Individual Provider's information, not Group information)
- Referring To Provider Information (Provider/Group/Facility rendering the service)
- Requestor's contact information
- Requested procedures and codes
- Diagnosis codes
- Clinical Documentation supporting the request
- Date of service and Number of units

Expected Turn Around Times

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

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 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

To contact the CHA Prior Authorization/Referrals Department:

- Phone: (800) 387-1103, Select option 2
- Fax: (855) 867-0868

**A list of services approved for Direct Referrals and services that require Prior Authorization, please access the Prior Auth Reference Guide on the CHA website: [Authorizations - CHOC Health Alliance](#)*

EZ-Net Provider Portal

EZ-Net Services

EZ-Net is CHA's secure provider portal: <https://eznet.rchsd.org/>

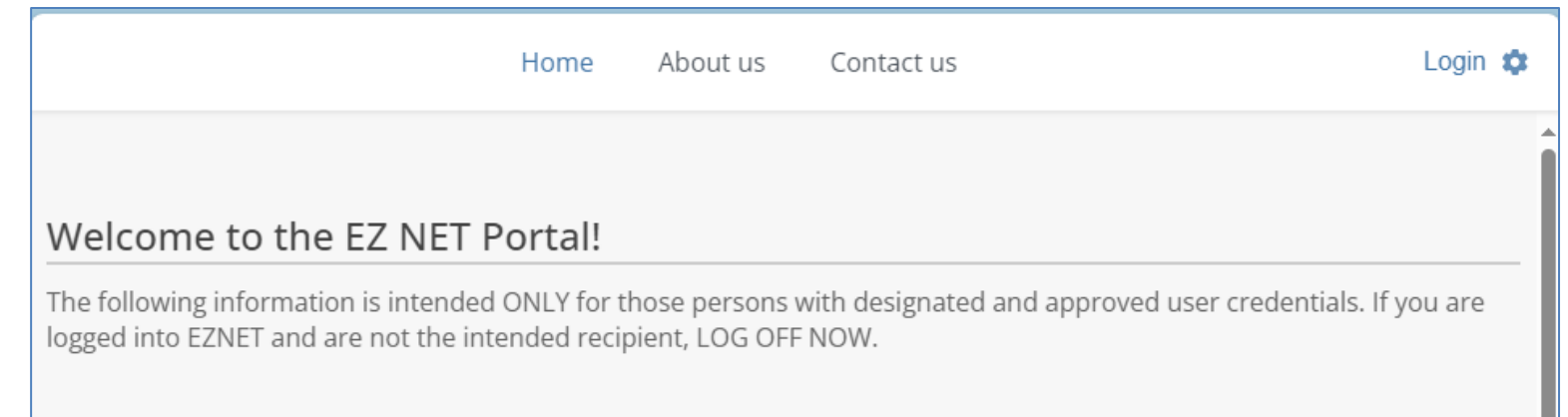
Use EZ-Net to:

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

How to request an EZ-Net account

- Fill out the User Request Form: [EZ NET User Request Form](#)
- Email the form to EZNetSupport@rchsd.org
- Users will receive their username and temporary password via email
- Each user must have their own login and password

For EZ-Net training contact Provider Relations at providerrelations@choc.org



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: _____

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 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. If CHA denies a request for a second opinion, CHA will notify the member in writing.

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

Clinical Programs



Model of Care Programs

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 contact 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.

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 Case Management Referral 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

Claims



BACK TO TOP

Billing Procedures

Provider 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 our contracted clearinghouse:

<u>Vendor Name</u>	<u>Payer ID</u>	<u>Contact</u>	<u>Website</u>
Office Ally	CHOC1	(866) 575-4120	https://cms.officeally.com/

Paper Claim Submission

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

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

NOTE: All claims that have attachments must be submitted via paper submissions

All 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 clean claim. A clean claim is a claim that requires no additional information and is free of errors.

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/Dispute 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 Provider Dispute Resolution (PDR) Form at [Provider Manual and Forms](#)
- Fill out the form and attach supporting documentation
- Send the completed form and documents to:

<u>Via Mail</u>	<u>Via Physical Delivery</u>
Rady Children’s Hospital – San Diego Attn: CHOC/CPN Claims 3020 Children’s Way, MC 5144 San Diego, CA 92123	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 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 OHC
- 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.)

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



BACK TO TOP

ECHO Health

ECHO Health

The ECHO Health platform for payment and remittance activity creates access and increased visibility into every payment.

ECHO Provider Payments Portal: [ECHO Provider Direct - Login \(providerpayments.com\)](https://providerpayments.com)

- Pull EOB/EOP reports
- Pull capitation reports

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

- [Paper check](#)
- [Virtual Card \(Vcard\)](#) – virtual visa debit transaction (This is the default option for new providers)
 - To manage Virtual Card payments or change payment method, providers can update via [ECHO VCARD](#)
 - For Vcard specific inquiries, you may call (877) 705-4230
- [EFT/ACH](#) – automatic direct deposit to a bank account
 - To enroll, providers can enroll online [ECHO Health \(echohealthinc.com\)](https://echohealthinc.com) or email EDI@echohealthinc.com
 - Single Payer: No service fee
 - All Payer: 1.99% service fee

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

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
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

Emergency and Urgent Care Services

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

Access Standards

Appointment Access Standards continued

Other Access Standards

Type of Care	Standard
Physical Accessibility	Provider physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities
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

Type of Care	Standard
Telephone Nurse Triage or Screening Services	Telephone triage or screening shall be available 24/7. Telephone nurse triage or screening waiting time shall not exceed 30 minutes
Telephone access after/during business hours for emergencies	The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room
After-hours access	A PCP or designee shall be available 24/7 to respond to after-hours calls from members or a hospital emergency room practitioner

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 alternative 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.

Contracted providers are expected to comply with these appointments, telephone access, practitioner availability and linguistic service standards. CalOptima Health monitors providers for compliance. CalOptima Health may develop corrective action plans for providers that do not meet these standards.

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: [Cultural Competency](#)

Including Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex and Asexual (LGBTQIA+) cultural competency training

Diversity, Equity, and Inclusion Training - consists of 3 eLearning courses:

- ❖ Health Equity Fundamentals
- ❖ Diversity, Equity, Inclusion, and Belonging
- ❖ Cultural Competency: The Foundation of Equitable Health Care



DEI Training -
eLearning courses



DEI Additional
Resources

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.

Quality Improvement (HEDIS)



HEDIS

Cozeva

Quality Improvement Workplan

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.

Quality Improvement (HEDIS)

Cozeva

Cozeva is a NCQA (National Committee for Quality Assurance) HEDIS certified platform for Pay for Performance. Cozeva is the operating system that aggregates and transforms multiple data streams 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



BACK TO TOP

CHOC Health Alliance Contact List

<u>Resources</u>	<u>Contact Information</u>
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 Representatives

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



Provider Relations Department

ProviderRelations@choc.org