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| Policy: | HH.2015 |
| Title: | **Health Networks Claims Processing** |
| Department: | Claims Administration |
| Section: | Not Applicable |
| *CEO Approval:* | */s/ Michael Hunn 05/09/2024* |
| Effective Date: | 01/01/2010 |
| Revised Date: | 05/01/2024 |
| Applicable to: | ☒ Medi-Cal<br>☒ OneCare<br>☒ PACE<br>☐ Administrative |

## I. PURPOSE

This Policy addresses Health Network requirements related to delegated claims settlement practices and CalOptima Health's oversight of the Health Networks' compliance with these requirements.

## II. POLICY

A. A Health Network shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the Health Network's contract with CalOptima Health, as well as the provisions of this Policy and applicable laws and regulations.

B. A Health Network shall ensure timely compliance with claims payment obligations and claims settlement practices.

C. In the event the Health Network fails to timely and accurately reimburse its claims and the Health Network has not established a Corrective Action Plan (CAP) required and approved by CalOptima Health and consistent with Health and Safety Code, Section 1375.4(b)(4) and CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions, CalOptima Health shall take appropriate corrective action, which may include, but is not limited, de-delegation of claims payment.

D. A Health Network shall not improperly deny, adjust, or contest a claim and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

E. A Health Network shall establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve Provider disputes that meet the requirements of CalOptima Health Policies HH.1101: Provider Complaint and MA.9006: Provider Complaint Process. A Health Network shall make all records, notes, and documents regarding its Provider dispute resolution mechanism(s) and the resolution of its Provider disputes available to CalOptima Health and any requesting regulatory agency.

F. A Health Network shall resolve its Provider disputes in a timely manner, including the issuance of a written decision, in accordance with CalOptima Health Policies HH.1101: Provider Complaint and MA.9006: Provider Complaint Process. CalOptima Health shall monitor and ensure the administration of the Health Network's dispute resolution mechanism(s) and for the timely resolution of Provider disputes.

G. A Health Network shall forward all Medicare Non-Contracted Provider Complaints to CalOptima Health in a timely manner. All Medicare Non-Contracted Provider Complaints will be processed in accordance with CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process.

H. A Health Network shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of Provider claims.

I. For OneCare: A Health Network shall reimburse a provider for Emergency Services and, if applicable, its affiliated providers for related services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

## III. PROCEDURE

A. Claim Filing Deadlines

1. Medi-Cal: A Health Network shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a Participating Provider and one hundred and eighty (180) calendar days for a Non-participating Provider after the date of service, except as required by state or federal law or regulation.

2. OneCare: For a Non-Contracted Provider a Health Network shall not impose a deadline for the receipt of a claim that is less than twelve (12) months or one (1) calendar year after the date the services were furnished. For a Contracted Provider a Health Network shall not impose a deadline for the receipt of a claim that is less than the time frame specified in the contracted provider agreement. If the Contracted Provider agreement does not specify a time frame, the Contracted Provider shall submit a claim within twelve (12) months, or one (1) calendar year after the date the services were furnished.

3. If a Health Network denies a claim because it was filed beyond the claim filing deadline, the Health Network shall, upon a Provider's submission of a Provider dispute pursuant to Title 28, California Code of Regulations, Section 1300.71.38, and the demonstration of good cause for the delay, accept and adjudicate the claim in accordance with Health and Safety Code, Sections 1371 or 1371.35, whichever is applicable.

4. If the Health Network is not the primary payer under coordination of benefits, the Health Network shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than ninety (90) calendar days from the date of payment or date of contest, denial, or notice from the primary payer.

B. Claims Processing Timeliness

1. Medi-Cal

a. A Health Network shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

b. A Health Network shall process and adjudicate one hundred percent (100%) of contracted and non-contracted Clean and Non-clean Claims for Covered Services provided to a

Member within forty-five (45) business days after the Health Network's receipt of such claims.

c. A Health Network shall process and adjudicate ninety-nine percent (99%) of claims for Covered Services provided to a Member within ninety (90) calendar days after the Health Network's receipt of the claim.

d. A Health Network shall process and adjudicate ninety-nine percent (99%) of claims for Covered Services provided to a Member within ninety (90) calendar days after the Health Network's receipt of the claim.

2. OneCare

a. A Health Network shall process and adjudicate ninety-five percent (95%) of Clean Claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

i. For claims not furnished under a written agreement with the submitting provider, a Health Network shall process ninety-nine percent (99%) of Clean Claims for Covered Services provided to a Member within thirty (30) calendar days after the Health Network's receipt of such Clean Claims.

b. All other claims from Non-Contracted Providers shall be paid or denied within sixty (60) calendar days from the date of the request.

c. A Health Network shall adhere to the Medicare Claims Processing Manual for the handling of all incomplete or invalid claims.

C. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the claim.

2. For a Provider claim that does not involve Emergency Services or Family Planning Services that is incorrectly sent to a Health Network, and the Provider that filed the claim is a Contracted Provider, within ten (10) business days of the receipt of the claim the Health Network shall either:

a. Medi-Cal: Send the Provider a notice of denial, within ten (10) business days, with instructions to bill the appropriate Health Network; or

b. OneCare: Send the Provider a notice of denial, within thirty (30) business days for non-contracted claims and sixty (60) business days for contracted claims, with instructions to bill the appropriate Health Network; or

c. Forward the claim to the appropriate Health Network.

3. In all other cases, for claims incorrectly sent to a Health Network, the Health Network shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

4. If a claim is sent to a Health Network and CalOptima Health is responsible for adjudicating the claim, the Health Network shall forward the claim to CalOptima Health within ten (10) business days after the receipt of the claim incorrectly sent to the Health Network.

D. Acknowledgment of Claims

1. In the case of an electronic claim, the Health Network shall identify and acknowledge the claim within two (2) business days after the date of receipt of the claim by the office designated to receive claims. Electronic claims received by 5 p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4 p.m. and 5 p.m., must be considered as received on that date.

2. In the case of a paper claim, the Health Network shall identify and acknowledge the claim within fifteen (15) business days after the date of receipt of the claim by the office designated to receive claims. Paper claims received by 5 p.m. on a business day, or by closing time if the Health Network routinely ends its public business day between 4 p.m. and 5p.m., must be considered as received on that date. A paper claim received after the routine close of business between 4 p.m. and 5 p.m. is considered received on the next business day.

3. If a Provider submits a claim using a Health Network's claims clearinghouse, the Health Network's identification, and acknowledgment to the clearinghouse within the time frames set forth in subparagraph 1 and 2 of this Section, whichever is applicable, shall constitute compliance.

E. Interest on Late Claims

1. Medi-Cal

a. The Health Network shall pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.D of this policy.

b. A Health Network shall automatically include, for late payment on a Complete Claim for Emergency Services and care, the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

c. A Health Network shall automatically include, for late payments on all other claims other than Complete Claims for Emergency Services and care, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

d. If the interest due on an individual claim is less than two dollars ($2), a Health Network may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. The Health Network shall make lump interest payments within ten (10) calendar days of the calendar month's end.

e. If a Health Network fails to automatically include the interest due on a late claim payment, the Health Network shall pay the Provider a ten-dollar ($10) penalty for that late claim, in addition to any amounts due.

2. OneCare

a. Interest shall begin to accrue on the thirty-first (31st) business day for non-contracted, Non-clean Claims, and sixty-first (61st) calendar days for contracted Non-clean Claims,

calculated based on calendar days. Interest is paid at the rate used for Section 3902(a) of Title 3l, U.S. Code and rounded to the nearest penny. The interest rate is determined by the applicable rate on the day of payment. Interest shall be calculated using the following formula:

i. [Payment Amount x Rate x Days] divided by [365 (366 in a leap year)] = Interest Payment

F. Denying, Adjusting, or Contesting a Claim

1. A Health Network may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within forty-five (45) business days after the date of receipt of the claim by the Health Network for the Medi-Cal program and within thirty (30) business days for non-contracted Claims and sixty (60) calendar days for non-contracted claims for OneCare.

   a. If the Health Network contests a portion of a claim, it must reimburse any uncontested portions of the claim within the statutory timeframes.

2. If the Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, the Health Network shall provide a clear, accurate, and written explanation of the necessity for the request. If the Health Network subsequently denies the claim based on the Provider's failure to provide the requested Medical Records or other information, any dispute arising from the denial of such claim shall be handled through a Provider dispute resolution process. The Health Network is prohibited from requesting irrelevant or unnecessary information from Providers during claims processing.

3. If a Health Network fails to provide the Provider with written notice that a claim has been contested or denied within the allowable time period pursuant to Section III.F.1. of this Policy, or requests information from the Provider that is not reasonably relevant information or requests information from a third party that is in excess of the information necessary to determine payer liability, but ultimately pays the claim in whole or in part, the Health Network shall compute the interest or impose a penalty pursuant to Section III.E. of this Policy.

4. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. The Health Network shall either contest or deny within the time frames set forth in Section III.F.1 of this Policy, in writing, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. The Health Network shall identify in the denial or contest the individual or entity that was requested to submit information, the specific documents requested and the reason(s) why the information is necessary to determine payer liability.

G. Reimbursement for the Overpayment of Medi-Cal Claims

1. If a Health Network determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the Health Network believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. If the Provider contests the Health Network's notice of reimbursement of the overpayment of a claim, the Provider, within sixty (60) calendar days of the receipt of the notice of overpayment of a claim, shall send written notice to the Health Network stating the basis upon which the

Provider believes that the claim was not overpaid. The Health Network shall receive and process the contested notice of overpayment of a claim as a Provider dispute pursuant to Title 28, California Code of Regulations, Section 1300.71.38 and CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Provider Complaint Process, as applicable.

3. If the Provider does not contest the Health Network's notice of reimbursement of the overpayment of a claim, the Provider shall reimburse the Health Network within sixty (60) calendar days of the receipt by the Provider of the notice of overpayment of a claim.

4. For the Medi-Cal program, if the Provider does not reimburse the Health Network for the overpayment of a claim within sixty (60) calendar days after receipt of the Health Network's notice, interest shall accrue at the rate of ten percent (10%) per annum beginning with the first (1st) calendar day after the thirty (30) business day period.

5. A Health Network may only offset an uncontested notice of reimbursement of the overpayment of a claim against a Provider's current claim submission when:

   a. The Provider fails to reimburse the Health Network within the time frame in Section III.F.3 of this Policy; and

   b. The Provider has entered into a written contract specifically authorizing the Health Network to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, the Health Network shall provide the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

H. A Heath Network shall pay interest and applicable penalties.

1. Medi-Cal: For all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.E. of this Policy. The interest rate is determined by California Health and Safety Code Section 1371 or 1371.35, whichever is applicable.

2. OneCare: For all non-contracted claims not paid within thirty (30) calendar days and sixty (60) calendar days for all contracted claims after the day of receipt of the claim on a per claim basis, in accordance with Section III.E. of this Policy. The interest rate for all non-contracted claims is determined by Title 31 of the United States Code (U.S. Code), Section 3902(a), and Title 42 Code of Federal Regulations (CFR), Section 422.520 in accordance with Sections 1816(c)(2)(C) and 1842(c)(2)(C) of the Social Security Act of 1935, as amended for the period beginning on the thirty-first (31st) day after receipt and ending on the date the Health Network makes payment. The interest rate for all contracted claims is determined by the provisions of the contract between the Health Network and the Provider.

I. A Health Network shall submit to CalOptima Health all required claims performance reports within fifteen (15) calendar days after the close of each calendar month or thirty (30) calendar days after the close of each calendar quarter in a format specified by CalOptima Health. Required reports shall, at a minimum, disclose the Health Network's compliance status with the provisions of this Policy, CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting, the California Code of Regulations, the Health and Safety Code, Code of Federal Regulations (CFR) and Centers for Medicare & Medicaid Services (CMS) requirements.

J. A Health Network shall provide a participating Provider upon contracting, annually, and upon the participating Provider's written request, the following information in a paper or electronic format,

which may include a website containing this information, or another mutually agreeable accessible format:

1. Directions, including the mailing address, email address, and facsimile number, for the electronic transmission (if available), physical delivery, and mailing of claims, all claim submission requirements including a list of commonly required attachments, supplemental information, and documentation consistent with reasonably relevant information, instructions for confirming the Health Network's receipt of claims consistent with Section III.C. of this Policy, and a telephone number for claims inquiries and filing information;

2. The identity of the office responsible for receiving and resolving Provider disputes;

3. Directions, including the mailing address, email address, and facsimile number for the electronic transmission (if available), physical delivery, and mailing of Provider disputes and all claim dispute requirements, the timeframe for the Health Network's acknowledgement of the receipt of a Provider dispute and a telephone number for provider dispute inquiries and filing information;

4. Directions for filing substantially similar multiple claims disputes and other billing or contractual disputes in batches as a single Provider dispute that includes a numbering scheme identifying each dispute contained in the bundled case.

5. Complete fee schedule for the participating Provider consistent with the disclosures specified in Title 28, California Code of Regulations, Section 1300.75.4.1(b); and

6. Detailed payment policies and procedures and rules and non-standard coding methodologies used to adjudicate claims, which shall unless otherwise prohibited by state law:

    a. When available, be consistent with Current Procedural Terminology (CPT) and Medi-Cal or Medicare Coding, the standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations;

    b. Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments; and

    c. At a minimum, clearly and accurately state the policies regarding the following:

        i. Consolidation of multiple services or charges and payment adjustments due to coding changes;

        ii. Reimbursement for multiple procedures;

        iii. Reimbursement for assistant surgeons;

        iv. Reimbursement for the administration of immunizations and injectable medications; and

        v. Recognition of CPT and Medi-Cal modifiers.

K. A Health Network shall provide a minimum of forty-five (45) calendar days prior written notice before instituting any changes, amendments, or modifications in the disclosures pursuant to Section III.G of this Policy.

1. A Health Network, with the agreement of the participating Provider, may utilize alternate transmission methods to deliver any disclosure required by this policy, as long as the participating Provider can readily determine and verify that the required disclosures have been transmitted or are accessible and the transmission method complies with all applicable state and federal laws and regulations.

2. The Health Network shall supplement its electronic transmission with paper communication that satisfies the disclosure requirements pursuant to any limitations on the Health Network's ability to electronically transmit any required disclosures as found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended.

L. Managing Claims for Timeliness Compliance

1. A Health Network shall monitor the paid, denied, and pended claims reports daily to ensure that claims are correctly processed and coded, and that the claims meet the timeline requirements.

2. A Health Network shall ensure that timeline reports are completed weekly and shall develop specific action plans to address any deficiencies noted in such reports.

3. A Health Network shall provide the results of any deficiencies noted in a claims audit conducted by the Health Network.

4. A Health Network shall document and maintain action plans related to individual examiners or to the unit as a whole for periodic review by CalOptima Health or the Health Network.

M. Claims Audit and Oversight

1. CalOptima Health's Audit & Oversight Department shall continue to provide oversight of all Delegated Health Networks claims activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

## IV. ATTACHMENT(S)

Not Applicable

## V. REFERENCE(S)

A. California Health and Safety Code, §§1371 through 1371.39, & 1375.4(b)(4)
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Policy GG.1619: Delegation Oversight
F. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
G. CalOptima Health Policy HH.2002: Sanctions
H. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
I. CalOptima Health Policy HH.2005: Corrective Action Plan
J. CalOptima Health Policy HH.5000: Provider Overpayment and Investigation
K. CalOptima Health Policy MA.9006: Provider Complaint Process
L. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
M. Centers for Medicare & Medicaid Services (CMS) Claims Processing Manual
N. Department of Health Care Services (DHCS) All Plan Letter (APL) APL 23-020: Requirements for Timely Payments of Claims

O. Health Network Service Agreement
P. Social Security Act, §§1816(c)(2)(C) and 1842(c)(2)(C)
Q. Title 28, California Code of Regulations, §§1300.71, 1300.71.38, 1300.71.4, and 1300.77.4
R. Title 31, United States Code (U.S.C.), §3902(a)
S. Title 42, Code of Federal Regulations (C.F.R.), §§422.520(a) and 447.45
T. Title 42, United States Code (U.S.C.), §§1396a(a)(37) and 1396u-2(b)(2)(D)

## VI. REGULATORY AGENCY APPROVAL(S)

| Date | Regulatory Agency | Response |
|---|---|---|
| 03/31/2010 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 12/10/2010 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 05/20/2016 | Department of Health Care Services (DHCS) | Approved as Submitted |
| 11/09/2023 | Department of Health Care Services (DHCS) | Approved as Submitted |

## VII. BOARD ACTION(S)

| Date | Meeting |
|---|---|
| 12/07/2017 | Regular Meeting of the CalOptima Board of Directors |
| 12/06/2018 | Regular Meeting of the CalOptima Board of Directors |
| 12/05/2019 | Regular Meeting of the CalOptima Board of Directors |
| 12/03/2020 | Regular Meeting of the CalOptima Board of Directors |
| 12/20/2021 | Special Meeting of the CalOptima Board of Directors |

## VIII. REVISION HISTORY

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| Effective | 01/01/2010 | HH.2015 | Health Networks Claims Processing | Medi-Cal |
| Revised | 01/01/2011 | HH.2015 | Health Networks Claims Processing | Medi-Cal |
| Revised | 02/01/2013 | HH.2015 | Health Networks Claims Processing | Medi-Cal |
| Revised (Policy Reinstated) | 10/01/2015 | HH.2015 | Health Networks Claims Processing | Medi-Cal |
| Revised | 01/01/2016 | HH.2015 | Health Networks Claims Processing | Medi-Cal |
| Revised | 12/07/2017 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/06/2018 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/05/2019 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/03/2020 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect |
| Revised | 12/20/2021 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect<br>PACE |
| Revised | 03/01/2023 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect |

| Action | Date | Policy | Policy Title | Program(s) |
|---|---|---|---|---|
| | | | | PACE |
| Revised | 07/01/2023 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect<br>PACE |
| Revised | 10/01/2023 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect<br>PACE |
| Revised | 12/01/2023 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>OneCare Connect<br>PACE |
| Revised | 05/01/2024 | HH.2015 | Health Networks Claims Processing | Medi-Cal<br>OneCare<br>PACE |

## IX. GLOSSARY

| Term | Definition |
|---|---|
| Clean Claim | Medi-Cal: A claim that can be processed without obtaining additional information from the provider of the service or from a third party.<br><br>OneCare: A claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare. |
| Complaint | The general term used to identify all provider-filed requests for review and expressions of dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes Appeals, disputes and Grievances. |
| Complete Claim | A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information and information necessary to determine payer liability as defined in Title 28, California Code of Regulations (CCR) section 1300.71 (a)(10) and (a)(11). |
| Contested Claim | A claim submitted for payment that is considered an incomplete claim submission and that is contested by the health plan as a result of the claim not containing all reasonably relevant information to determine payer liability. |
| Contracted Provider | A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima Health, its contracted Health Networks or Physician Groups. |
| Coordination of Benefits | A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan. |
| Corrective Action Plan (CAP) | A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators. |
| Covered Services | Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.<br><br>Covered Services do not include:<br><br>1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services |

| Term | Definition |
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| | Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services;<br>2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services;<br>3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services);<br>4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services);<br>5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members);<br>6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis);<br>7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services;<br>8. Prayer or spiritual healing as specified in 22 CCR section 51312;<br>9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services);<br>10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH);<br>11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;<br>12. State Supported Services;<br>13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005;<br>14. Childhood lead poisoning case management provided by county health departments; |

| Term | Definition |
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| | 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;<br>16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and<br>17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.<br><br>OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.<br><br>PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors. |
| Denied Claim | A claim for which payment could not be made due to some defect, such as the patient was not a Member, the services were not covered services, the claim was not filed in a timely manner, etc. |
| Emergency Medical Condition | Medi-Cal: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:<br><br>1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;<br>2. Serious impairment to bodily function;<br>3. Serious dysfunction of any bodily organ or part; or<br>4. Death<br><br>OneCare: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:<br><br>1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy;<br>2. Serious impairment to bodily functions; and/or<br>3. Serious dysfunction of any bodily organ or part.<br><br>PACE: A condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with average knowledge of health/medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy of the health of the Participant; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. |

| Term | Definition |
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| Emergency Services | Medi-Cal: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).<br><br>OneCare: Those covered inpatient and outpatient services required that are:<br><br>1. Furnished by a physician qualified to furnish emergency services; and<br>2. Needed to evaluate or stabilize an Emergency Medical Condition. |
| Family Planning Services | Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to:<br><br>1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning;<br>2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures;<br>3. Patient visits for the purpose of Family Planning;<br>4. Family Planning counseling services provided during regular patient visit;<br>5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices;<br>6. Tubal ligations;<br>7. Vasectomies;<br>8. Contraceptive drugs or devices; and<br>9. Treatment for the complications resulting from previous Family Planning procedures.<br><br>Family Planning does not include services for the treatment of infertility or reversal of sterilization. |
| Focused Review | An audit that specifically targets areas of potential deficiency. |
| Health Network | A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network. |
| Member | A beneficiary who is enrolled in a CalOptima Health program. |
| Non-clean Claim | Medi-Cal: A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Non-clean claim shall have the same meaning as incomplete claim submission.<br><br>OneCare: A claim for Covered Services that lacks required documentation such as medical records or authorization numbers. |
| Non-Contracted Provider | Medi-Cal: A Provider who is not obligated by written contract to provide Covered Services to a Member.<br><br>OneCare: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network. |

| Term | Definition |
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| Provider | Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.<br><br>OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. |