Policy:	FF.2005
Title:	**Conlan, Member Reimbursement**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 11/22/2024*
Effective Date:	01/01/2007
Revised Date:	11/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's process to comply with the Department of Health Care Services (DHCS) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, the court-ordered reimbursement process to Members for paid out-of-pocket expenses for Medi-Cal Covered Services.

II. POLICY

A. CalOptima Health, in compliance with DHCS APL 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process, and in accordance with applicable state and federal regulations, shall reimburse Members for out-of-pocket expenses for Covered Services through the terms and conditions of this Policy.

B. If CalOptima Health or a Health Network denies all or part of the Member's claim, the Member shall have the right to appeal the decision in accordance with CalOptima Health Policy GG.1510: Member Appeal Process.

C. Providers and Practitioners shall have the option to file a State Hearing and provide evidence that the proposed reimbursement and recoupment is not correct for *Conlan* claims only.

D. CalOptima Health may recoup from Health Networks, Providers, and Practitioners to reimburse a Member in accordance with the provisions set forth in this Policy.

E. CalOptima Health, its Health Networks, Providers, and Practitioners shall not submit claims to, or demand, or otherwise collect reimbursement from, a Member, in accordance to Title 22, California Code of Regulations (CCR), Section 51002.

F. CalOptima Health shall report and investigate any suspected Fraud, Waste, and Abuse matters, pursuant to CalOptima Health Policies HH.1105: Fraud, Waste, and Abuse Detection, and HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

G. If a Member does not fully comply with the provisions set forth in this Policy, CalOptima Health may deny the Member's claim.

III. PROCEDURE

A. Subject to the provisions of this Policy, and in accordance with the DHCS APL 07-002, CalOptima Health shall reimburse a Member for paid out-of-pocket expenses for Covered Services received on and after June 27, 1997, during the following specific periods of a Member's eligibility:

1. The retroactive period (up to three (3) months prior to the time of application).

2. The evaluation period (from the time of application to the Medi-Cal program until the issuance of the Member's Medi-Cal card).

3. The post-approval period (the time period after eligibility has been established).

B. Claims Submission Timelines

1. For services received on or after November 16, 2006, claims must be submitted within one year of receipt of services or within ninety (90) days after issuance of the Medi-Cal card, whichever is longer.

C. CalOptima Health and its Health Networks shall only be responsible to provide reimbursement for Covered Services for which CalOptima Health and its Health Networks receive Capitation Payment, subject to all applicable CalOptima Health and Health Network utilization protocols, policies, and procedures as of the date of service, including, but not limited to:

1. Utilization Management controls and limitations, as set forth in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals;

2. Non-emergency Medical Transportation, as set forth in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical;

3. Disposable incontinence supplies, as set forth in CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies; and

4. Durable Medical Equipment (DME), as set forth in CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs.

D. CalOptima Health and the Health Network shall be responsible for reimbursing services for which payment may have been issued by the Member or another person on behalf of the Member.

E. CalOptima Health and the Health Network shall be responsible to provide reimbursement for Physician Administered Drugs (PADs) for dates of service January 1, 2022, and after when administered outside of a pharmacy setting, including any PADs or devices dispensed related to an individual's Intrauterine Device. A PAD will be a Medi-Cal RX benefit when it meets the following criteria:

1. The PAD is specifically listed on the Contract Drug List.

2. There is a pharmacy Prior Authorization justifying the Medical Necessity as to why the medically administered drug needs to be billed as a pharmacy claim.

3. Pursuant to Social Security Act Section 1927(k)(3), the benefit will include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, Renal dialysis.

F. CalOptima Health and its Health Networks are not obligated to provide reimbursement for the following services:

1. Carved-Out Services (i.e., Medi-Cal services for which CalOptima Health and its Health Networks are not responsible);

2. Services rendered to a Member during a time period outside of those specified in Section III.A. of this Policy;

3. Services for which pre-authorization was required but not obtained, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals;

4. Services for which a Member went out-of-network to receive non-emergency services; and

5. Services that were rendered by a Provider or Practitioner who was not a Medi-Cal Provider on the date of service.

G. CalOptima Health shall adjudicate *Conlan* reimbursement claims within one hundred twenty (120) calendar days after CalOptima Health's receipt of a completed claim packet from the Department of Health Care Services (DHCS) or its agent for CalOptima Health-covered expenses incurred and paid during the time periods referenced in Section III.A. of this Policy. Excluded from the *Conlan* Adjudication Period are the time periods between mailing of a notice to a Member that additional information is required to process a claim, and receipt of such information, and any period during which a recoupment action is in effect against the Provider who owes a reimbursement.

IV. ATTACHMENT(S)

A. Provider Notice A: CalOptima Health Requests Medi-Cal Provider to Reimburse the Member
B. Provider Notice B: CalOptima Health Requests Non-Medi-Cal Provider to Reimburse the Member
C. Provider Notice C: Provider Obligation to Reimburse Member and Submit Claim to CalOptima Health
D. Member Notice A: Claim Closed due to Full Reimbursement from Provider
E. Member Notice B: Additional Information Required to Process Claim
F. Member Notice C: Claim Denial
G. Member Notice D: Direct Reimbursement from CalOptima Health to Member for Medi-Cal Rate
H. Member Notice E: Confirmation of Receipt of Claim

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies
C. CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
D. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy GG.1510: Member Appeal Process
G. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
H. CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting

I. Department of Health Care Services (DHCS) Notice to Medi-Cal beneficiaries
J. Department of Health Care Services (DHCS) Notice to Medi-Cal Rx: Post Transition roles & Responsibilities
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 07-002: Conlan v. Bontá: Conlan v. Shewry: Court Ordered Medi-Cal Beneficiary Reimbursement Process
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-012: Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX (Supersedes APL 20-020) (Revised: 12/30/2022)
M. Title 22, California Code of Regulations (CCR), Section 51002

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
10/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/19/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	07/01/2009	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	03/01/2012	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	10/01/2016	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2017	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2018	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	05/01/2019	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	12/03/2020	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	10/01/2021	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	02/01/2022	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	09/01/2022	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	03/01/2023	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	05/01/2023	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	04/01/2024	FF.2005	Conlan, Member Reimbursement	Medi-Cal
Revised	11/01/2024	FF.2005	Conlan, Member Reimbursement	Medi-Cal

IX. GLOSSARY

Term	Definition
Capitation Payment	The monthly amount paid to a Health Network by CalOptima Health for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Covered Services	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. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in 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 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 this Contract, 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; 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; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 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); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 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); 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; 8. Prayer or spiritual healing as specified in 22 CCR section 51312;

Term	Definition
	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); 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); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 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; 14. Childhood lead poisoning case management provided by county health departments; 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; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 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.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Durable Medical Equipment (DME)	Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.
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.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Non-Emergency Medical Transportation	Means ambulance, litter van, wheelchair van, and air medical transportation services. NEMT is used when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and pursuant to 22 CCR sections 51323, 51231.1, and 51231.2, is rendered by licensed Providers.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	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.