Policy:	HH.1105
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/ Michael Hunn 11/19/2024*
Effective Date:	06/01/1999
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process to detect suspected Fraud, Waste, or Abuse (FWA) in a CalOptima Health program by a Member, Provider or Prescribing Provider, Practitioner, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), Billing Intermediary, and CalOptima Health's Health Networks, in accordance with federal and state regulations.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward Fraud, Waste, and Abuse.

B. CalOptima Health shall follow the process for detecting suspected Fraud, Waste, or Abuse, outlined in this policy.

C. CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

D. CalOptima Health's Pharmacy Management Department shall identify Fraud and Abuse of controlled substances by Members, Prescribing Providers, and Pharmacies dispensing drugs to Members, by conducting drug claim reviews and monitoring utilization safety standards, to detect opioid related misuse, and refer cases to the Office of Compliance in accordance with CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities.

E. CalOptima Health's Office of Compliance shall investigate, and report suspected Fraud, Waste, or Abuse, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

F. CalOptima Health shall provide regular training and information sessions to its Employees and FDRs regarding Fraud, Waste, and Abuse, and shall inform Members regarding Fraud, Waste, and Abuse and the provisions of this policy.

G. CalOptima Health Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith. CalOptima Health shall treat the detection of suspected FWA in a confidential manner to the extent possible.

III. PROCEDURE

A. CalOptima Health may detect Fraud, Waste, or Abuse by a Member in circumstances that include, but are not limited to, the following:

MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using (selling, loaning, or giving) another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with services or prescriptions obtained from multiple areas of service; Members who attempt more than one PCP
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; Members who attempt more than one PCP; reports of Members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was prescribed, or using a Covered Service inappropriately	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other	Any source
M08	Member Pharmacy Utilization	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M09	Doctor Shopping	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; Pharmacy report; PBM reports; data analytics; claims data; Encounter data; FWA software

B. CalOptima Health may detect Fraud, Waste, or Abuse by an FDR (i.e., Provider, Vendor) in circumstances that include, but are not limited to, the following:

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima Health program	Provider information not able to be verified during credentialing or contracting process; Providers on the excluded Provider list

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; Encounter data; FWA software; coding edits
P03	Submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; verification surveys; Hotline report; Member interviews
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P05	Submission of claims for Covered Services that are that are billed using a code that would result in greater payment than the code that reflects the Covered Services	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima Health and another third-party payer without full disclosure	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; payment by OHI
P08	Charging a Member in excess of allowable co-payments and deductibles for Covered Services	Member report; Hotline report; oversight audits; Member interviews
P09	Billing a Member for Covered Services without obtaining written consent to bill for such service	Member report; Hotline report; oversight audits; Member interviews
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a Member	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; Hotline report
P13	False certification of Medical Necessity	Medical Record review; claims data; Encounter data; FWA software
P14	Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement	Medical Record review; claims data; Encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline report; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with clinical, Encounter or payment records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations	Medical Record review; claims data; Encounter data; FWA software; Member interviews

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P17	Other	Any source
P18	Provider Pharmacy Utilization.	PBM or prescription reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; Hotline report; oversight Audits.
P20	Durable Medical Equipment- covered services that are not actually provided to a member.	Member report; Hotline report; oversight Audits; verification surveys.

C. CalOptima Health may detect Fraud, Waste, or Abuse by an Employee in circumstances that include, but are not limited to, the following:

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Hotline report; Data analytics; Referrals to SIU
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain	Hotline report, Referrals to SIU
E03	Employee assistance to Providers with the submission of false claims for Covered Services that are not actually provided to the Member for which the claim is submitted	Hotline report; Referrals to SIU
E04	Employee deceptively accessing company confidential information for purpose of a gain	Hotline report; Data analytics; Referrals to SIU

D. Training

1. CalOptima Health's Office of Compliance shall provide regular training and education to Employees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith and in accordance with CalOptima Health Policy HH.5004: False Claims Act Education.

2. CalOptima Health shall provide regular FWA training and information sessions to:

   a. New Employees, upon hire;

   b. CalOptima Health Employees, on an annual basis; and

   c. Health Networks, on an annual basis.

3. CalOptima Health shall provide Members with information related to FWA through:

   a. The Member Handbook;

   b. Periodic communications; and

c. The CalOptima Health website.

E. Detection

1. CalOptima Health may receive Complaints of suspected FWA from sources, including but not limited to:

   a. CalOptima Health's Compliance and Ethics Hotline;

   b. Claims data history;

   c. Encounter data;

   d. Medical Records audits;

   e. Member and Provider Complaints, appeals, and grievance reviews;

   f. Utilization Management reports;

   g. Provider utilization profiles;

   h. Pharmacy data;

   i. Monitoring and auditing activities;

   j. Memorandums and resources from CMS;

   k. Referrals from DHCS;

   l. Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or

   m. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the Health Networks' Compliance Programs to ensure that the programs are in place, are comprehensive, and in compliance with CalOptima Health contractual requirements.

3. CalOptima Health shall utilize "claims edits" in accordance with federal and state regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima Health shall conduct data validation reviews by auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, Medical Records, and all affiliated documentation related to the claims and Encounters.

5. CalOptima Health shall utilize data analytics including software to identify potential FWA cases. This data compares CalOptima Health claims and Encounters against national data to identify any suspected instances of FWA. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima Health shall perform reviews on data samples to test for potential FWA through methods, including, but not limited to:

    a. Reviewing utilization by doctor, specialty, and geographic comparison;

    b. CalOptima Health's Pharmacy Department shall refer cases to the SIU for Members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima Health shall implement a Service Verification Survey process to survey a sampling of Members as needed. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and industry findings and best practices. The Service Verification process may be used to ensure that:

    a. Covered Services that were billed were received;

    b. Face-to-face, or telehealth, services were provided for services/equipment/medications requiring recent or regular face-to-face, or telehealth, appointments;

    c. Durable Medical Equipment (DME) that were billed were received; and

    d. Medications that were billed were received.

F. CalOptima Health shall attend and participate in DHCS's quarterly program integrity meetings, as scheduled.

G. Upon detection of suspected Fraud, Waste, and/or Abuse, the Office of Compliance shall review the suspected activity in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

H. CalOptima Health shall treat the detection of suspected Fraud, Waste, or Abuse in a confidential manner, and shall not retaliate or make retribution against any CalOptima Health Employee, FDR, or Member for such detection, in accordance with CalOptima Health policy HH.3012: Non-Retaliation for Reporting Violations.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
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 Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
G. CalOptima Health Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting
H. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
I. CalOptima Health Policy HH.5004: False Claims Act Education

J. Department of Health Care Services All Plan Letter (APL) 23-026: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012)(Revised 02/20/2024)
K. Title 31, United States Code (U.S.C.), §3730(h)
L. Title 42, Code of Federal Regulations (C.F.R.), §§455.2 and 438.608
M. Welfare and Institutions Code, §§14026 and 14107.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
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
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/01/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	02/01/2013	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	12/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Service	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. Covered Services do not include: 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 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

Term	Definition
	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; 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;

Term	Definition
	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. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. 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.
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.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Durable Medical Equipment (DME)	Medi-Cal: 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. OneCare & PACE: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These

Term	Definition
	services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, physician groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
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.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Medically Necessary or Medical Necessity	Medi-Cal: 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

Term	Definition
	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. OneCare: Reasonable and necessary medical 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 includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
Member	A beneficiary enrolled in a CalOptima Health Program.
Other Health Coverage (OHC)	Medi-Cal: Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements. OneCare: Evidence of health coverage other than OneCare including, but not necessarily limited to: 1. The CalOptima Health Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and/or 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
Personal Representative	Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.

Term	Definition
Pharmacy	An area, place, or premise licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed.
Pharmacy Benefit Manager (PBM)	Medi-Cal: The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement. OneCare: An entity that provides Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
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.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
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. 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, etc.) 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.

Term	Definition
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.