Policy:	FF.2001
Title:	**Claims Processing for Covered Services for which CalOptima Health is Financially Responsible**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 02/21/2025*
Effective Date:	01/01/2007
Revised Date:	02/01/2025
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health ensures timely and accurate processing of claims for Covered Services for which CalOptima Health is financially responsible.

II. POLICY

A. CalOptima Health shall process claims in compliance with Title 42, United States Code (U.S.C.), Section 1396a(a)(37), and Health and Safety Code Sections 1371 through 1371.39.

B. CalOptima Health 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 provisions of this Policy and the California Code of Regulations.

C. CalOptima Health shall ensure timely compliance with claims payment obligations and claims settlement practices.

D. CalOptima Health shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a participating Provider or 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.

E. CalOptima Health shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt. CalOptima Health may provide an electronic method of notification, by which the Provider may readily confirm CalOptima Health's receipt of the claim and the recorded date of receipt within fifteen (15) business days of receipt of the claim.

F. CalOptima Health may review a claim for National Correct Coding Initiative (NCCI) edits and may contest or deny a claim based on improper coding. CalOptima Health may subcontract with a third-party vendor to review claims for NCCI edits and improper billing practices.

G. Claims Processing Timelines

1. CalOptima Health shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services, including American Indian Health Services Program providers, within thirty (30) calendar

days after CalOptima Health's receipt of such Clean Claims.

2. CalOptima Health shall process and adjudicate ninety-nine (99%) of claims for Covered Services, including American Indian Health Services Program providers, within ninety (90) calendar days after CalOptima Health's receipt of such claim.

3. CalOptima Health shall notify a Provider of an Unclean Claim for Covered Services, within forty-five (45) business days after receipt of such claim. If CalOptima Health fails to notify the Provider of the Unclean Claim, CalOptima Health shall consider the claim a Clean Claim, and shall pay, in accordance with the timelines for Clean Claims as set forth in this Policy.

H. CalOptima Health shall reimburse a Provider claim for Covered Services for which CalOptima Health is responsible, in accordance with CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible. Covered Services shall include payment for Emergency and Family Planning Services, which do not require authorization.

1. CalOptima Health shall reimburse a non-contracted hospital or Practitioner for Covered Services provided to a Member for which CalOptima Health is financially responsible, that has received appropriate authorization, unless exempt from such authorization, in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, or the Shared Risk Group's Prior Authorization.

I. CalOptima Health shall have a process to recoup Overpayments made to Providers and suppliers when claims payments exceed the allowed amount.

1. CalOptima Health may recoup Overpayments for a look-back period not to exceed six (6) years from current calendar year.

2. The six (6) year time limit shall not apply if the Overpayment was caused in whole, or in part, by Fraud, or misrepresentation, on the part of the Provider.

3. Failure to timely repay Overpayments will result in the addition of interest charges.

J. CalOptima Health shall not request reimbursement for the Overpayment of a claim, including requests made pursuant to Health and Safety Code, Section 1371.1, unless CalOptima Health sends a written request for reimbursement to the Provider within six (6) years from the date the Overpayment was made.

K. CalOptima Health shall pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.G. of this Policy. The interest is determined by Health and Safety Code, Section 1371 or 1371.35, whichever is applicable.

L. CalOptima Health 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.

M. CalOptima Health 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 CalOptima Health.

N. CalOptima Health 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 a Provider claim.

O. CalOptima Health shall submit all required reports and documents regarding claims payment practices and claims settlement practices to the Department of Health Care Services (DHCS).

P. CalOptima Health shall identify and process Overpayment recoveries in accordance with applicable statutory, regulatory and contractual requirements, as well as regulatory guidance, CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination, and Section III.I. of this Policy.

1. DHCS may impose Corrective Action Plans (CAPs) as well as administrative and/or monetary sanctions for non-compliance with DHCS All Plan Letter (APL) 23-011: Treatment of Recoveries Made by the Managed Care Health Plans of Overpayment to Providers.

Q. CalOptima Health shall maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and Covered Services for which payment is claimed.

R. CalOptima Health shall maintain sufficient claims processing, tracking and payment systems capability to comply with applicable State and Federal laws, regulations, and Contract requirements, to determine status of received claims and to estimate incurred and unreported claims amounts.

S. DHCS may impose Corrective Action Plans (CAPs) as well as administrative and/or monetary sanctions for non-compliance with any of the following outlined procedures in this policy.

T. CalOptima Health shall establish and maintain a fair, fast, and cost-effective Provider Dispute process. CalOptima Health shall annually make available to DHCS all records, notes, and documents regarding its Provider Dispute resolution mechanisms and the resolution of its Provider Disputes.

U. CalOptima Health's Claims Administration Department shall inform a Provider in the remittance advice of their right to file a Complaint with CalOptima Health's Grievance and Appeals Resolution Services (GARS) Department, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

III. PROCEDURE

A. A Provider shall verify a Member's eligibility to receive Covered Services, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

B. For Members assigned to CalOptima Health Direct Administrative (COHD-A) or CalOptima Health Community Network (CHCN), a Provider shall obtain authorization for Covered Services, in accordance with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

C. Members with Other Health Coverage or Medicare

1. If a Member has Other Health Coverage (OHC) or Medicare, a Provider shall submit a claim for Covered Services provided to the Member to the Other Health Coverage or Medicare prior to submitting the claim to CalOptima Health, in accordance with CalOptima Health Policy FF.2003: Coordination of Benefits.

2. CalOptima Health processes Crossover Claims for Members with secondary benefits under Medi-Cal. A Provider may submit Crossover Claims to CalOptima Health, in accordance with the Medi-Cal Provider Manual guidelines for Crossover Claims.

3. If a claim is received and is lacking the required OHC documentation, the claim shall be returned to the Provider and handled as a corrected claim once the documentation is received.

D. Claims Submission

1. A Provider shall utilize the following standard forms for submitting claims for Covered Services:

   a. A Provider shall use the CMS-1500 (Attachment A) when submitting a claim for professional services and supplies;

   b. A Provider shall use the UB-04 Form (Attachment B) when submitting a claim for hospital inpatient or outpatient services;

   c. An Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) shall use the UB-04 Claim Form (Attachment B), effective February 1, 2024, when submitting a claim for long-term care services; and

   d. For Child Health and Disability Prevention Program (CHDP) services, a Provider shall use the appropriate CMS-1500 (Attachment A) or UB-04 Claim Form (Attachment B) and standard CPT and HCPCS codes when submitting a claim for Pediatric Preventive Services. Claims for COHD-A or CHCN Members shall continue to be submitted to CalOptima Health, while claims for delegated Health Network Members shall be submitted to the appropriate Health Network.

2. A Provider shall submit a claim on the appropriate form with supporting documentation, including required prior authorizations and proof of Medicare or Other Health Coverage payment or denial.

3. A Provider may submit invoices, electronic or paper claims to CalOptima Health for Covered Services.

   a. A Provider may elect to submit electronic claims to CalOptima Health utilizing the process outlined in the CalOptima Health Provider Manual, Section H3: Electronic Claim Submissions: CalOptima Health Direct, Shared risk and OneCare (HMO D-SNP) Claims. This is located on the Provider section of the CalOptima Health website.

   b. A Provider who submits a paper claim shall submit the original claim form and retain a copy for the Provider's files. CalOptima Health shall not accept carbon copies, photocopies, computer generated copies, or facsimiles of paper claims.

   c. A Provider may submit paper claims to CalOptima Health by mail, or in person, at the following addresses:

      i. By mail:
      Attn Claims Department
      CalOptima Health
      Post Office Box 11037
      Orange CA 92856

      ii. In person:
      Claims Department
      CalOptima Health
      505 City Parkway West
      Orange CA 92868

4. A Provider shall bill accordingly for services rendered based on bill type and specialty. Claims elements include but are not limited to the following:

    a. Member Information;

    b. Provider of Service;

    c. Date of Service;

    d. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS);

    e. Applicable Revenue code (Institutional only);

    f. Applicable modifier (information and/or financial when required);

    g. Place of Service;

    h. Service Units; and

    i. Billed Charges.

E. Claim Filing Deadlines

1. A Provider shall submit a claim for Covered Services within three hundred sixty-five (365) calendar days after the month of the date of service.

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

F. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to CalOptima Health, CalOptima Health 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 CalOptima Health, and the Provider that filed the claim is a participating Provider, CalOptima Health shall either:

a. Send the Provider a notice of denial via a remittance advice, within ten (10) business days, with instructions to bill the Health Network; or

b. Forward the claim to the appropriate Health Network, within ten (10) business days of the receipt of the claim.

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

G. Interest on Late Claims

1. Interest shall begin to accrue on the forty-sixth (46th) business day following receipt of the claim and is calculated based on calendar days.

2. CalOptima Health shall automatically include for late payment on a Complete Claim for Emergency Services 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.

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

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

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

H. Denying, Adjusting, or Contesting a Claim

1. CalOptima Health 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.

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

2. In the event that CalOptima Health requests reasonably relevant information from a Provider; in addition to information that the Provider submits with a claim, CalOptima Health shall provide a clear, accurate, and written explanation of the necessity for the request. CalOptima Health is prohibited from requesting irrelevant or unnecessary information from Providers during claims processing.

3. If CalOptima Health fails to provide the Provider with timely written notice that a claim has been contested or denied, or requests information that is not reasonably necessary to determine payer liability, but ultimately pays the claim in whole or in part, CalOptima Health shall compute the interest or impose a penalty, pursuant to Section III.G. 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. CalOptima Health shall either contest or deny, in writing and within the time frames set forth in Section III.G. of this Policy, 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. CalOptima Health shall identify in the denied or contested claim, 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.

5. If CalOptima Health subsequently denies the claim based on the Provider's failure to provide the requested medical records or other information, any Provider Dispute arising from the denial of such

claim shall be handled in accordance with Title 28, California Code of Regulations, Section 1300.71.38.

6. Any claim submitted by a Provider that is flagged as "Do Not Pay" in the Provider Data Systems database will be denied.
   a. A "Do Not Pay" flag is entered into the Provider Data System for:

      i. Excluded Network Providers or Subcontractors for services provided after the effective date of the suspension or exclusion.

      ii. Decertified or suspended LTC Facilities for all services provided after the effective date of the suspension or exclusion.

      iii. Network Providers or Subcontractors for services on payment suspensions until payment suspension or exclusion has been lifted.

I. Reimbursement for the Overpayment of Claims

1. Overpayment Identified by Providers

   a. Network Providers shall report to CalOptima Health when it has identified an Overpayment and return such Overpayment to CalOptima Health within sixty (60) calendar days after the date on which the Overpayment was identified. The Provider shall notify the CalOptima Health Claims Administration Department, in writing, of the reason for the Overpayment and the Claims Administration Department shall coordinate with the Provider on the process to return the Overpayment to CalOptima Health as referenced in 42 CFR Section 438.608(a)(2).

2. Overpayment Identified by CalOptima Health

   a. If CalOptima Health 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 include a clear explanation of the basis upon which CalOptima Health believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

   b. If the Network Provider contests CalOptima Health'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 CalOptima Health's GARS Department stating the basis upon which the Provider believes that CalOptima Health's notice was in error. Out of Network Providers have thirty (30) working days of the receipt of the notice of Overpayment of a claim, pursuant Health and Safety Code section 1371.1. CalOptima Health shall receive and process the contested notice of Overpayment of a claim as a Provider Dispute, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

   c. If the Network Provider does not contest CalOptima Health's notice of reimbursement of the Overpayment of a claim, the Provider shall reimburse CalOptima Health within sixty (60) calendar days of the receipt, by the Provider, of the notice of Overpayment of a claim. Out of Network Provider has thirty (30) working days of the receipt of the notice of Overpayment of a claim, pursuant Health and Safety Code section 1371.1.

   d. If the Provider does not reimburse CalOptima Health for the Overpayment of a claim within sixty (60) calendar days after receipt of CalOptima Health's notice, interest shall accrue at the

rate of ten percent (10%) per annum, beginning with the first (1st) calendar day after the sixty (60) calendar day period. Out of Network Provider has thirty (30) working days of the receipt of the notice of Overpayment of a claim, pursuant Health and Safety Code section 1371.1.

e. CalOptima Health may only offset an uncontested notice of reimbursement of the Overpayment of a claim against a Provider's current claim submission when:

i. The Provider fails to reimburse CalOptima Health within the time frame set forth in Section III.I.2. of this Policy; or

ii. The Provider has entered into a written contract specifically authorizing CalOptima Health to offset an uncontested notice of Overpayment of a claim from the current claim submissions.

f. 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, CalOptima Health 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.

3. CalOptima Health shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity and shall promptly refer such identified suspected Overpayment to CalOptima Health's Special Investigations Unit (SIU) and/or DHCS as outlined in CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination.

4. CalOptima Health shall provide effective training and education for its compliance officer and all employees. This training shall include reporting to DHCS when Overpayments are identified or recovered, specifying which Overpayments are due to potential Fraud.

a. CalOptima Health shall notify its DHCS Managed Care Operations Division (MCOD) contract manager and DHCS audits and Investigation Unit at piu.cased@dhcs.ca.gov within ten (10) days of identifying Overpayment, regardless of the amount as referenced in Title 42, Code of Federal Regulations (CFR), Section 438.608(a)(2).

5. Retention and Reporting of Overpayment

a. CalOptima Health shall retain all Overpayments less than twenty-five million dollars ($25,000,000).

b. CalOptima Health shall document all Overpayments retained by CalOptima Health and review reports bi-annually for accuracy.

i. CalOptima Health shall require the Claims Administration Department and Network Providers to submit Overpayment recovery activities quarterly to the Accounting Department.

c. On an annual basis, CalOptima Health shall submit a report to DHCS on the recoveries of Overpayments, including those made to a Provider that was otherwise excluded from participation in the Medicaid program, and those made to a Provider due to Fraud, Waste or Abuse. CalOptima Health shall submit the report through the rate setting process and, in a manner, specified by DHCS.

d. Upon identification of an Overpayment to a Provider of twenty-five million dollars ($25,000,000) or more in a single instance, CalOptima Health shall share the recovery amount with DHCS equally.

i. CalOptima Health shall report such Overpayment to the DHCS Contract Manager within sixty (60) calendar days after the Overpayment was identified.

ii. CalOptima Health shall submit the Overpayment amount that was recovered, the reason for Overpayment, the services the Overpayment related to, the Provider's information, and steps taken to correct future occurrences to the DHCS Contract Manager.

e. CalOptima Health shall report and return any payment to DHCS within sixty (60) calendar days of when it has identified any capitation payments or other payments it has received or paid in excess of the amounts specified by DHCS.

6. CalOptima Health shall submit documentation including retention policies, process, time frames, and documentation required for reporting the recovery of all Overpayments, upon request by DHCS.

J. CalOptima Health shall retain claims information data for a period of at least ten (10) years after the termination of its contract with the DHCS and shall not remove or transfer such records and data from its offices, except in accordance with applicable laws.

K. CalOptima Health shall hold harmless and indemnify Members for CalOptima Health's debt to Providers for Covered Services rendered and billed to Members.

L. CalOptima Health shall maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and contract requirements, to determine the status of received claims and to estimate Incurred But Not Reported (IBNR) claims.

IV. ATTACHMENT(S)

A. CMS-1500
B. UB-04 Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy FF.2003: Coordination of Benefits
F. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
I. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
J. CalOptima Health Provider Manual
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers (Supersedes APL 17-003)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-020: Requirements for Timely Payment of Claims

O. Health and Safety Code, §§1371 through 1371.39
P. Medi-Cal Provider Manual
Q. Title 22, California Code of Regulations, §§ 53220 and 53222
R. Title 28, California Code of Regulations, §§ 1300.71 and 1300.71.38
S. Title 42, United States Code, § 1396a(a)(37)
T. Title 42, Code of Federal Regulations (CFR), § 438.608(a)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
01/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
02/05/2024	Department of Health Care Services (DHCS)	File and Use
11/21/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2007	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	08/01/2008	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2009	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2012	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	01/01/2013	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	12/01/2014	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2015	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	07/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	06/07/2018	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	05/01/2019	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	01/01/2022	FF.2001	Claims Processing for Covered Services for which CalOptima is Financially Responsible	Medi-Cal
Revised	01/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	06/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	08/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	12/07/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	02/01/2024	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	11/01/2024	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	02/01/2025	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal

IX. GLOSSARY

Term	Definition
Abuse	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.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Health Direct Administrative (COHD-A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members as described in CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for persons eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.
Clean Claim	A claim that can be processed without obtaining additional information from the Provider or from a third-party, including invoices that meet DHCS established billing and invoicing requirements.
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 section 1300.71 (a)(10) and (a)(11).
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 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

Term	Definition
	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; 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.
Crossover Claims	A claim submitted for payment for a Medi-Cal Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
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.
Dispute	A claims payment dispute regarding an amount paid that is less than the expected rate.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Emergency Services	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).
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: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
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).

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Incurred But Not Reported (IBNR)	An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
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.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Other Health Coverage	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.
Overpayment	Any payment made by CalOptima Health to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima Health by DHCS to which CalOptima Health is not entitled to under Title XIX of the Social Security Act.
Pediatric Preventive Services (PPS)	Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the Child Health and Disability Prevention (CHDP) Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.
Provider	For the purposes of this policy, a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, physician group, Health Network, or other person or institution that furnishes Covered Services.
Provider Complaint	The general term used to identify all provider filed request for review, and expressions of, dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes appeals, disputes and grievances.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Subcontractor	An individual or entity who has a Subcontract with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Unclean Claim	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. Unclean claim shall have the same meaning as incomplete claim submission.

Term	Definition
Waste	The overutilization or inappropriate utilization of services and misuse of resources.