Policy:	HH.1106
Title:	**Pay and Educate Criteria—Provider Complaints**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/14/2023*
Effective Date:	01/01/2003
Revised Date:	12/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the circumstances and process, by which CalOptima Health shall resolve a Provider or Practitioner Complaint related to a decision to deny payment for a service administratively, based upon noncompliance with CalOptima Health's policies related to authorization of Covered Services.

II. POLICY

A. CalOptima Health's Grievance Process shall allow for education of, and payment to, a Provider or Practitioner that may be unfamiliar with CalOptima Health policy regarding administrative procedures for obtaining requisite authorizations for Covered Services.

B. CalOptima Health shall consider resolving a Provider or Practitioner Complaint through a pay and educate decision when the following circumstances can be reasonably determined:

1. The Provider or Practitioner is either:

   a. Out of county and unfamiliar with the CalOptima Health program and its authorization requirements; or

   b. In county, has limited experience with CalOptima Health, and is unfamiliar with CalOptima Health's authorization requirements.

2. CalOptima Health has not previously issued a pay and educate decision with regard to the Provider or Practitioner through the Grievance Process;

3. The Provider or Practitioner has not received previous education regarding CalOptima Health's authorization requirements, as evidenced by CalOptima Health's Appeal files, CalOptima Health Direct or CalOptima Health Community Network authorization request and Appeal files, and based on CalOptima Health's claims history with the Provider or Practitioner; and

4. The Provider or Practitioner has not agreed to, or received, a settlement for the services that are the subject of the Complaint.

C. CalOptima Health shall not consider a pay and educate decision when the administrative non-compliance issue is related to federal submission requirements, such as for those for Minimum Data Set (MDS), Certification for Special Treatment Program (HS231), or Preadmission Screening and Resident Review (PASRR).

D. CalOptima Health shall only apply a pay and educate Complaint resolution decision to a Provider or Practitioner one (1) time.

E. CalOptima Health's Grievance and Appeals Resolution Services (GARS) Director, or their Designee, shall have the authority to determine if CalOptima Health may resolve a Provider or Practitioner Complaint through the application of a pay and educate decision.

III. PROCEDURE

A. CalOptima Health shall process Provider or Practitioner Complaints resolved through a pay and educate decision, in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint, MA.9006: Provider Complaint Process and MA.9009: Non-Contracted Provider Payment Appeals.

B. The resolution letter shall set forth:

1. The reason for the decision;

2. Explain that it is a one-time exception; and

3. Provide the requisite education to the Provider or Practitioner so that the Provider or Practitioner may avoid denials for similar circumstances in the future.

C. To ensure that the Grievance Process applies pay and educate decisions in a consistent manner, and on a one-time-basis only to any one (1) Provider or Practitioner, the Complaint shall be logged in the Complaint tracking system as a pay and educate in the "decision reason" field.

D. The GARS staff shall refer authorizations and claims related to pay and educate decisions to the appropriate CalOptima Health departments for review and processing, in accordance with CalOptima Health policy and guidelines.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
B. CalOptima Health Policy MA.9006: Provider Complaint Process
C. CalOptima Health Policy MA.9009: Non-Contracted Provider Payment Appeals

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2003	HH.1106	Pay and Educate Criteria-Provider Complaints	Medi-Cal
Revised	06/01/2007	HH.1106	Pay and Educate Criteria-Provider Complaints	Medi-Cal
Revised	07/01/2016	HH.1106	Pay and Educate Criteria-Provider Complaints	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	HH.1106	Pay and Educate Criteria-Provider Complaints	Medi-Cal OneCare OneCare Connect
Revised	08/01/2019	HH.1106	Pay and Educate Criteria-Provider Complaints	Medi-Cal OneCare OneCare Connect
Revised	12/01/2023	HH.1106	Pay and Educate Criteria - Provider Complaints	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination.
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 (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

Term	Definition
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. OneCare Connect: A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100),, or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Term	Definition
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima Health's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
Grievance Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.
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.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. 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. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.