Policy:	GG.1539
Title:	**Authorization for Out-of-Network and Out-of-Area Services**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 05/23/2024*
Effective Date:	11/01/2015
Revised Date:	05/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes requirements and process for authorization of Out-of-Network and Out-of-Area Covered Services for Members assigned to CalOptima Health Direct or a Health Network.

II. POLICY

A. CalOptima Health and its delegated Health Networks must authorize services through Out-of-Network Providers if the network of CalOptima Health or its Health Networks fail to meet network adequacy requirements. In doing so, Members may utilize any Provider in or out of CalOptima Health's network regardless of Health Network affiliation and in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.

B. If CalOptima Health delegates Utilization Management activities to a Health Network, in accordance with CalOptima Health Policy GG.1541: Utilization Management Delegation, the Health Network shall be responsible for authorization determinations for Member referrals for Covered Services:

1. Out-of-Network for Medi-Cal, and/or OneCare, as applicable;

2. Out-of-Area, as directed by the Health Network, for Medi-Cal, and/or One Care, as applicable.

C. CalOptima Health or a Health Network may authorize Out-of-Network and Out-of-Area Covered Services, as applicable, if a Member, due to his or her medical condition, requires:

1. Covered Services from a Non-Contracted Provider;

2. Specialty care that is not available within the network, which may include an OB/GYN acting as a primary care physician;

3. For Medi-Cal, care from a Mandatory Provider, when there is no contract with a Mandatory Provider and no Mandatory Provider is available in the Service Area. CalOptima Health or a Health Network may arrange for transportation to the Mandatory Provider in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical; and/or

4. Tertiary facility specialty care that is not available within the network.

D. Out-of-Area shall include out-of-state, as specified in Section III.D. of this Policy.

E. CalOptima Health or a Health Network shall process requests for Covered Services in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

F. CalOptima Health or a Health Network shall review all requests and notices for Covered Services for a Member utilizing criteria described in CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines.

G. CalOptima Health or a Health Network shall ensure that Members eligible with the Whole-Child Model (WCM) program are provided accurate information on how to request and seek approval for Out-of-Network Covered Services.

H. Covered Services not subject to prior authorization are set forth in 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.

I. CalOptima Health or a Health Network shall review any request for post-service authorization of Covered Services provided to a Member when submitted 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.

J. CalOptima Health or a Health Network shall ensure Continuity of Care for a Member transitioning from traditional Fee-For-Service (FFS), another Medi-Cal Managed Care Plan, or California Children's Services (CCS) program into the WCM program, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services, MA.6021a: Continuity of Care for New Members, and GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program.

K. Upon approval of an Alternative Access Standard for a Core Specialist by the Department of Health Care Services (DHCS), CalOptima Health or a Health Network shall:

1. Assist any requesting Member in obtaining an appointment with an Out-of-Network Core Specialists, either in person or via Telehealth, within time or distance standards as outlined in CalOptima Health Policy GG.1600: Access and Availability Standards;

2. Attempt to establish a Member-specific case agreement with an Out-of-Network Core Specialist in accordance with Section III.E. of this Policy, and CalOptima Health Policies GG.1600: Access and Availability Standards and EE.1141: CalOptima Health Provider Contracts;

    a. If the Member-specific case agreement cannot be established, CalOptima Health or a Health Network must arrange for an appointment with an in-network specialist.

3. Ensure the Out-of-Network Core Specialist is within applicable time or distance standards pursuant to CalOptima Health Policy GG.1600: Access and Availability Standards; and

4. If the Out-of-Network Core Specialist is not within applicable time or distance standards pursuant to CalOptima Health Policy GG.1600: Access and Availability Standards, CalOptima Health or a Health Network shall arrange for non-emergency medical transportation or non-

medical transportation, as applicable, and in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency & Non-Medical.

5. Members shall follow CalOptima Health or Health Network's authorization policies and procedure to obtain appropriate approvals prior to accessing an Out-of-Network Provider.

III. PROCEDURE

A. For Covered Services, network Providers, including Specialty Care Practitioners, shall refer the Member to another network Provider (contracted Provider), unless a Provider of the required type is unavailable in-network. Referrals to an Orange County Out-of-Network Provider shall be processed in accordance with Section III.C of this policy. Referrals to an Out-of-Area Provider shall be processed in accordance with Section III.B of this policy.

1. For Sensitive Services, Members may access any Provider, including those who are Out-of-Network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network.

2. For a complex cancer diagnosis, if CalOptima Health and its delegated Health Networks are unsuccessful in good faith contracting efforts, Members must be allowed to request a referral to receive Medically Necessary services through an Out-of-Network cancer center, unless the Member chooses a different cancer treatment Provider as long as CalOptima Health and its Health Networks and the Out-of-Network cancer center come to an agreement with respect to payment.

B. Authorization for Out-of-Area Covered Services:

1. For Medi-Cal only, upon determination that a Member requires Out-of-Area Covered Services, the referring Practitioner shall request authorization from the Member's Health Network, or CalOptima Health for CalOptima Health Direct Members, 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.

   a. Upon notice of a Member's acute admission to an Out-of-Area facility, the Member's Health Network, or CalOptima Health's case management nurse for CalOptima Health Direct Members, shall conduct concurrent review until the Member is discharged.

   b. Prior to a Member's discharge from an Out-of-Area facility, the Member's Health Network, or CalOptima Health Utilization Management Department for CalOptima Health Direct Members, shall be responsible for ensuring the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

      i. Performing appropriate discharge planning; and

      ii. Coordinating post-hospitalization services, as needed.

2. For OneCare, upon determination that a Member requires Out-of-Area Covered Services, the referring Practitioner shall request authorization from CalOptima Health's Utilization Management Department in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

a. If a Member's Health Network receives notification of a Member's admission to an Out-of-Area facility for Covered Services, the Health Network shall notify the CalOptima Health Utilization Management Department within twenty-four (24) hours.

b. Upon notice of a Member's acute admission to an Out-of-Area facility, a CalOptima Health case management nurse shall conduct concurrent review until the Member is discharged in accordance with CalOptima Health Policy GG.1501: Inpatient Length of Stay Assignment.

c. Prior to a Member's discharge from an Out-of-Area facility, the CalOptima Health Utilization Management Department and the Member's Health Network shall coordinate the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

C. Authorization for Out-of-Network Covered Services

1. For Medi-Cal, and OneCare, upon determination that a Member requires Covered Services Out-of-Network, the referring Practitioner shall request authorization from the Member's Health Network, or CalOptima Health for CalOptima Health Direct Members, in accordance with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, GG.1508: Authorization and Processing of Referrals, and GG.1501: Inpatient Length of Stay Assignment.

a. Upon notice of a Member's acute admission to an Out-of-Network facility, the Member's Health Network, or CalOptima Health for CalOptima Health Direct Members, shall conduct concurrent review until the Member is discharged.

b. Prior to a Member's discharge from an Out-of-Network facility, the Member's Health Network or CalOptima Health, for CalOptima Health Direct Members, shall be responsible for ensuring the provision of a Member's Covered Services throughout the post-discharge and transition to community-based care period, by:

i. Performing appropriate discharge planning; and

ii. Coordinating post-hospitalization services, as needed.

2. Whole-Child Model Program

a. For the WCM program, CCS-eligible Members and CCS-paneled Providers shall follow CalOptima Health or Health Network's authorization policies and procedure to obtain appropriate approvals prior to accessing an Out-of-Network CCS Provider;

b. CalOptima Health or a Health Network shall allow CCS-eligible Member's access to Out-of-Network CCS Providers, in accordance with CalOptima Health Policy GG.1660: Access and Availability Standards, in order to obtain Medically Necessary Covered Services related to the Members' CCS-eligible Condition, if:

i. CalOptima Health or a Health Network has no specialist that treats the CCS-Eligible Condition within the network;

ii. In-network Providers are unable to meet timely access standards, as described in CalOptima Health Policy GG.1600: Access and Availability Standards; or

iii. WCM Continuity of Care requirements are applicable to the WCM Member at the time the service is provided, as outlined in CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

c. CalOptima Health or a Health Network cannot deny Out-of-Network Covered Services based upon cost or location.

d. CalOptima Health or a Health Network shall ensure transportation is provided for CCS-eligible Members obtaining Out-of-Network Covered Services in accordance with CalOptima Health Policies GG.1547: Maintenance and Transportation and GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

D. Authorization for Out-of-State Providers

1. CalOptima Health or a Health Network shall allow access to an out-of-state Provider as follows:

a. For Emergency Services for an Emergency Medical Condition; or

b. With respect to the WCM program, if CalOptima Health or a Health Network has no CCS-paneled Providers available to provide Medically Necessary non-emergency services to treat the CCS-Eligible Condition within the state in accordance with DHCS Numbered Letter (NL) 09-1119: Authorization of Out of State Services Requests.

E. Establishing an LOA with an Out-of-Network provider, including Out-of-Area and out-of-state:

1. Upon determination that a Member requires Covered Services Out-of-Network, CalOptima Health shall:

a. Determine if the Provider is within the time or distance standards as provided in CalOptima Health Policy GG.1600: Access and Availability Standards;

b. The Utilization Management (UM) nurse shall forward the request to the Medical Director for review. If it is necessary for the Member to obtain Covered Services Out-of-Network, the Medical Director shall approve the LOA request.

c. If the Provider is approved, the UM nurse shall:

i. Fax an approval notification for the requested service to the referring Provider, noting that this approval is pending an LOA;

ii. Complete the LOA Request Form;

iii. Forward the LOA Request Form to the CalOptima Health Contracting Department to reach out to the Provider and reach an agreement and signature on the LOA; and

iv. Once an LOA is established, fax the LOA approval to the referring Provider.

IV. ATTACHMENT(S)

A. CalOptima Health Authorization Request Form (ARF) – Medi-Cal

B. CalOptima Health Authorization Request Form (ARF) - OneCare

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health, Health Network Service Agreement
D. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
E. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model-Coordination with County CCS Program
F. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
G. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
H. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
I. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
J. CalOptima Health Policy GG.1501: Inpatient Length of Stay Assignment
K. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
L. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
N. CalOptima Health Policy GG.1541: Utilization Management Delegation
O. CalOptima Health Policy GG.1547: Maintenance and Transportation
P. CalOptima Health Policy GG.1600: Access and Availability Standards
Q. CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
R. CalOptima Health Policy MA.6021a: Continuity of Care for New Members
S. Department of Health Care Services All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Services, on or After January 1,2023 , (Supersedes APL 22-032)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034: California Children's Services Whole Child Model Program (Supersedes APL 21-005)
V. Department of Health Care Services (DHCS) Numbered Letter (NL) 09-1119: Authorization of Out of State Services Requests
W. Senate Bill (SB) 987, Chapter 608: California Cancer Care Equity Act

VI. REGULATORY AGENCY APPROVAL

Date	Regulatory Agency	Response
12/31/2019	Department of Health Care Services (DHCS)	Approved as Submitted
10/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
05/10/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2015	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	08/01/2018	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	10/03/2019	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	05/01/2020	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	12/01/2021	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare
Revised	05/01/2023	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare
Revised	05/01/2024	GG.1539	Authorization for Out-of-Network and Out-of-Area Services	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining Providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
California Children's Services (CCS)-Eligible Condition	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
California Children's Services (CCS) Provider	Means any of the following Providers when used to treat Members for a CCS condition: 1. A medical Provider that is paneled by the CCS program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106. 2. A licensed acute care hospital approved by the CCS program. 3. A special care center approved by the CCS program.
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.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an Out-of-Network Provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and Timely placement at different levels of care including hospital, skilled nursing and home health care.
Core Specialist	Adult and pediatric providers as specified in Department of Health Care Services All-Plan Letter 20-003: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility

Term	Definition
	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 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);

Term	Definition
	10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. 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.
Emergency Medical Condition	Medi-Cal: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; 3. Serious dysfunction of any bodily organ or part; or 4. Death OneCare: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or

Term	Definition
	3. Serious dysfunction of any bodily organ or part.
Emergency Services	Medi-Cal: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1). OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
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.
Mandatory Provider	Providers who managed care plans must offer to contract with, where available, and include Federally Qualified Health Centers (FQHCs), Rural Health Centers, Freestanding Birthing Center (FBC), Certified Nurse Manager, Licensed Midwife, and Indian Health Facilities (IHFs), as defined in Department of Health Care Services All-Plan Letter 20-003: Network Certification Requirements.
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 twenty-one (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 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (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.
Member	A beneficiary enrolled in a CalOptima Health program.

Term	Definition
Non-Contracted Provider	Medi-Cal: A Provider that is not obligated by written contract to provide Covered Services to a Member. OneCare: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Out-of-Area	Outside of the Service Area.
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the Service Area Provider [CalOptima Health]: A Provider that does not participate in CalOptima Health's Network.
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.
Primary Care Practitioner/Physician (PCP)	Medi-Cal: A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic. OneCare: A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general Practitioner, internist, pediatrician, family Practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities, or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a non-physician Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
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,

Term	Definition
	ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Qualified Health Care Professional	A Primary Care Physician (PCP), specialist, or other licensed health care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, or condition.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Service Area	Medi-Cal: The county or counties that CalOptima Health is approved to operate in under the terms of the DHCS Contract. Currently, this covers Orange County, California. OneCare: The county or counties that CalOptima Health is approved to operate in under the terms of the 2024 D-SNP Contract. A Service Area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this D- SNP Contract
Specialty Care Provider or Specialty Care Practitioner	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.
Urgent Care Service	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.