Policy:	MA.4016
Title:	**Direct Member Reimbursement for Covered Services**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	12/05/2019
Revised Date:	10/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the circumstances and requirements under which CalOptima Health, or a Health Network may directly reimburse a OneCare Member for covered health care expenses rendered by a Provider upon completion of a coverage decision.

II. POLICY

A. A Provider shall bill CalOptima Health or the Health Network, as appropriate, for services rendered to a OneCare Member.

B. CalOptima Health OneCare Members retain the right to be reimbursed by CalOptima Health or a Health Network for any bill(s) paid in excess of the Member's cost sharing amount for Covered Services.

C. CalOptima Health or a Health Network shall directly reimburse a Member for a Covered Service if the Member was actively enrolled in OneCare, on the date of service (DOS), and has incurred the payment of the bill, in whole, or in part.

D. A Health Network shall reimburse a OneCare Member for a Covered Service if the Member was eligible with the CalOptima Health contracted Health Network on the DOS.

E. CalOptima Health shall process reimbursements to Members for prescription drugs in accordance with CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination.

F. In accordance with CalOptima Health policy, a OneCare Member shall directly request reimbursement any time after the date the health care service(s) was rendered.

1. If a OneCare Member does not request reimbursement, the OneCare Member shall be responsible for payment of the bill(s), with the following exception:

    a. There is a change to the OneCare benefits, pursuant to the Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS).

G. CalOptima Health or a Health Network shall deny a Direct Member Reimbursement (DMR) request if the Member or Provider did not comply with the Prior Authorization requirements outlined in CalOptima Health Policies GG.1508: Authorization and Processing of Referrals and GG.1539: Authorization for Out-of-Network and Out-of-Area Services, as applicable.

H. If the OneCare Member has not yet paid a bill or invoice submitted to CalOptima Health or a Health Network and CalOptima Health's or a Health Network determines that the service being billed is CalOptima Health's or a Health Network's financial responsibility, CalOptima Health or a Health Network shall directly pay the Provider for the service.

III. PROCEDURE

A. Direct Member Reimbursement

1. Within sixty (60) calendar days from receiving a OneCare Member's request for reimbursement, CalOptima Health or a Health Network shall directly reimburse a OneCare Member subject to the requirements of this Policy, when the OneCare Member directly paid out of pocket for Covered Services in the following circumstances:

    a. Emergency or Urgent Services received from an out-of-network Provider or out-of-area Provider;

        i. Maximum member reimbursement supplemental benefit amount per benefit year for Emergency or Urgent Services received outside of the United States as a supplemental covered benefit.

    b. The payment made by the OneCare Member exceeded their cost sharing amount;

    c. For a date of service that occurred during the Member's retroactive enrollment with CalOptima Health OneCare;

    d. For prescription refills using an in-network or out-of-network pharmacy;

    e. For the full cost of a prescription due to inability to provide proof of eligibility (e.g., not providing the CalOptima Health membership card); and/or

    f. For the full cost of a Covered Service or covered drug in other situations.

2. For Covered Services, a OneCare Member shall mail, fax, or email the reimbursement request to CalOptima Health, or a Health Network, based on Division of Financial Responsibility.

3. All OneCare direct member reimbursement (DMR) requests shall include:

    a. Proof of payment (a copy of the credit card charge slip(s) or online statement, canceled checks, a bank account statement, cash withdrawal slips, or a cruise ship statement); and

    b. Copy of itemized bill showing all services received. The bill must include the Member's name, address, phone number, tax ID of doctor and/or facility, and all diagnosis and procedure codes, if available; and

    c. Member written request to be reimbursed; and

d. Discharge summary or equivalent medical documentation; and

e. Authorization of Representative Form (CMS-1696) or equivalent notice, if applicable.

4. CalOptima Health, or a Health Network, shall review the OneCare Member's reimbursement request and make a coverage decision.

5. CalOptima Health, or a Health Network, shall outreach to the OneCare Member or Provider if additional information is necessary to make a determination for the reimbursement request.

6. CalOptima Health, or a Health Network, shall reimburse the OneCare Member for the Covered Service paid, if:

   a. Authorization is required, all authorization policies and procedures were complied with when obtaining the Covered Services; and

   b. The Covered Services rendered were deemed medically necessary after conclusion of CalOptima Health or a Health Network's Utilization Management departments medical review, as applicable; and

   c. Any payment made directly by a share of cost where the OneCare Member exceeded their share of cost; and

   d. The services paid for is a covered benefit under the OneCare program.

7. CalOptima Health, or a Health Network, shall not reimburse the OneCare Member for the service(s), paid if:

   a. The Member was ineligible with CalOptima Health or a Health Network on the DOS for which the reimbursement is being requested; or

   b. A Prior Authorization was required for the service but not obtained in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals; or

   c. The Member received out-of-network non-emergency services and did not adhere to CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services; or

   d. The service(s) rendered were deemed not medically necessary after medical review conducted by CalOptima Health or a Health Network's Utilization Management department; or

   e. The payment made by the OneCare Member did not exceed their share of cost; or

   f. The service obtained is not a covered benefit.

8. Within sixty (60) calendar days from receiving a OneCare Member request for reimbursement, if CalOptima Health or a Health Network denies a OneCare Member's reimbursement request, CalOptima Health or a Health Network shall provide a written and oral notice to the Member of the following information:

   a. A detailed explanation of the reason(s) for the denial;

b. An explanation of the OneCare Member's financial responsibility; and

c. The OneCare Member's right to appeal CalOptima Health's or a Health Network's decision.

9. A OneCare Member shall have a right to appeal CalOptima Health's or a Health Network's decision for the reimbursement request, in accordance with CalOptima Health Policies MA.9003: Standard Pre-Service Appeal and MA.9005: Payment Appeal.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special
B. Needs Plan (D-SNP)
C. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
E. CalOptima Health Policy MA.4008: Member Handbook Requirements
F. CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination
G. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
H. CalOptima Health Policy MA.9005: Payment Appeal
I. Medicare Managed Care Manual, Chapter 13: Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 40.10 (Effective July 19, 2024)
J. Title 42, Code of Federal Regulations §422.520

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2019	MA.4016	Direct Member Reimbursement for Covered Services	OneCare
Revised	03/01/2020	MA.4016	Direct Member Reimbursement for Covered Services	OneCare
Revised	07/01/2021	MA.4016	Direct Member Reimbursement for Covered Services	OneCare
Revised	11/01/2022	MA.4016	Direct Member Reimbursement for Covered Services	OneCare
Revised	10/01/2023	MA.4016	Direct Member Reimbursement for Covered Services	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2024	MA.4016	Direct Member Reimbursement for Covered Services	OneCare

IX. GLOSSARY

Term	Definition
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Emergency Medical Condition	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 3. Serious dysfunction of any bodily organ or part.
Emergency Services	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.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.

Term	Definition
Provider	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) 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.
Supporting Documentation	A bill, discharge summary or equivalent medical documentation, and proof of payment. Member written request to be reimbursed.
Urgent Care	Services furnished to a Member who requires services to be furnished within twelve (12) hours in order to avoid the likely onset of an Emergency Medical Condition.