Policy:	FF.2003
Title:	**Coordination of Benefits**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 04/04/2024*
Effective Date:	01/01/2007
Revised Date:	04/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health, and Health Networks shall coordinate benefits including, cost avoidance and post-payment recovery requirements, when a CalOptima Health Member has Other Health Coverage (OHC).

II. POLICY

A. If a Member has OHC, CalOptima Health and a Health Network shall consider the OHC plan as the Member's primary health plan.

B. CalOptima Health and a Health Network shall remain the secondary health plan and payer of last resort.

C. If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the OHC shall pay for the medical, other care, or treatment benefits. CalOptima Health and a Health Network, as a secondary health plan and payer of last resort, shall adjudicate the claim based on amounts allowed by CalOptima Health and the OHC, whichever is less.

D. CalOptima Health or a Health Network shall not consider payment until both Medicare and any OHC has made payment as appropriate for a Member that has received services that fall within Medicare and/or the OHC's scope of coverage or has denied payment as non-covered benefits.

E. CalOptima Health and a Health Network shall not consider a claim for a Member with a Medicare supplemental policy through an insurance carrier as a Medicare/Medi-Cal Crossover Claim. CalOptima Health and a Health Network shall consider the Medicare supplemental insurance carrier as the primary health plan and CalOptima Health and a Health Network as the secondary health plan and the payer of last resort.

F. CalOptima Health and a Health Network shall base the Coordination of Benefits (COB) claim determination period upon the period of time that the Member is actively eligible for Medi-Cal benefits. If there is a break in eligibility and the dates of service falls within the period of time when the Member is not covered by Medi-Cal, CalOptima Health and the Health Network shall not apply the COB rules to the claim.

G. CalOptima Health and a Health Network shall rely on the Medi-Cal Eligibility Record for cost avoidance and post-payment recovery purposes. Should CalOptima Health or a Health Network become aware of OHC from sources other than the Medi-Cal Eligibility Record, CalOptima Health or a Health Network may use this OHC information but must report the OHC to both DHCS and the OHC.

H. For the purpose of Post-Payment Recovery, the reasonable value of the services is the average payment CalOptima Health, or a Health Network pays for similar services in the particular service area, but in no event less than the Medi-Cal fee-for-service payment rate for the services rendered.

I. Effective February 9, 2018, in accordance with federal law, prenatal care is subject to cost avoidance. In cases where prenatal service billing is bundled with claims for other services, CalOptima Health and the Health Network shall ensure Providers cost avoid the entire claim.

III. PROCEDURE

A. If CalOptima Health identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS in All Plan Letter (APL) 22-027: Cost Avoidance and Post-Payment Recovery for Other Health Coverage.

1. To ensure timely, accurate and complete reporting to DHCS, if Health Network identifies OHC unknown to DHCS, the Health Network shall immediately report the OHC to the CalOptima Health Customer Service Department upon discovery.

2. For Health Networks for which CalOptima Health has approved direct reporting of OHC to DHCS, the Health Network shall report such OHC to DHCS in accordance with this Policy.

B. Prior to delivering services to Members, CalOptima Health or a Health Network shall ensure Providers review the Medi-Cal Eligibility Record for the presence of OHC. If a Member has active OHC, CalOptima Health or a Health Network shall ensure the Provider compares the OHC code (Appendix A to (APL) 22-027: Cost Avoidance and Post-Payment Recovery for Other Health Coverage) to the requested service. If the requested service is covered by the OHC, CalOptima Health and a Health Network shall ensure the Provider instructs the Member to seek the service from the OHC carrier.

C. CalOptima Health and a Health Network shall use the following indicators to assess a Member's claim for possible OHC including, but not limited to:

1. Claim forms or Provider billings:

   a. CMS-1500;

   b. UB-04; or

   c. 25-1.

2. CalOptima Health or FACETS™:

   a. Health plan carrier codes; or
   b. Medi-Cal eligibility aid codes.

3. Health Network:

    a. Health plan carrier code;

    b. Medi-Cal eligibility aid codes; or

    c. Other insurance information included in the CalOptima Health Member Eligibility tapes or through the file transfer protocol (FTP) site.

4. Automated Eligibility Verification System (AEVS): As listed on the Supplemental to AEVS Carrier Codes for Other Health Coverage;

5. Photocopies of Remittance Advice Details (RAD);

6. Explanation of Medicare Benefits (EOMB); or

7. Explanation of Payments to Providers (EOP) from other insurance payers.

D. COB Claims Process

1. CalOptima Health and a Health Network shall review the submitted claim form for indication of OHC. Pursuant to CMS-1500 or UB-04 claim forms, CalOptima Health and a Health Network shall utilize the following questions to review the claim form including, but not limited to:

    a. *Does the bill indicate the existence of other insurance coverage*?
    Universal claim forms (CMS-1500, UB-04, 25-1) used by physicians, hospitals, and other Providers usually indicate the type of coverage and the insurance carrier and may provide the group plan name and number. (See Box 11d on CMS-1500 – Is There Another Health Benefit Plan).

    b. *Has the bill been paid in part or in whole?*
    An attachment to the claim submitted as evidence or explanation of benefits (EOB) may indicate that another plan has already provided benefits. (See Box 29 on CMS-1500 – Amount Paid).

    c. *Is the spouse employed?*
    If the spouse is employed, the Member may have coverage under the spouse's employer's group health plan. Dependent children may have coverage as dependents under the spouse's coverage. (See Box 9c on CMS-1500 – Employer's Name)

    d. *Is the claimant covered by other plans that provide benefits or services?*
    Claim forms usually request this information, along with the type of coverage, the name of the insurance carrier, and the group number. (See Box 9a-d on CMS-1500 – Other Insured's Name and Insurance Information)

    e. *If the claimant is a child, does the last name differ from that of the insured or covered Member?*
    This may indicate coverage through a second parent or a divorce situation in which natural and stepparents cover the child.

    f. *Does the claim form indicate that the employee has a former employer?*
    This may indicate that the claimant is receiving coverage as a retiree under the former employer's group health plan.

g. *Does the claim form indicate that the claimant is covered under the State or Federal health insurance continuation program?*
This may indicate coverage under a former employer's group health plan (e.g., COBRA).

h. *Is the claimant aged sixty-five (65) or older?*
This may indicate the presence of Medicare coverage. (See Box 1 if the Medicare Box is checked and Box 3 on CMS-1500 – Patient's Birth Date)

i. *Is the claimant under age sixty-five (65) and diagnosed with end-stage renal disease (ESRD)?*
This may indicate that the claimant is entitled to Medicare coverage.

j. *If the claim was the result of an accident, where and how did it occur?*
This may indicate that the medical expenses are covered by a Third-Party Liability carrier, such as auto insurance or a homeowner's policy. (See Box 10b on CMS-1500 – Is Patient's Condition Related to Auto Accident or Box 21 on CMS-1500 – Description of Injury)

k. *Were the bills submitted as photocopies?*
This may indicate that the original bills were sent to another health plan carrier for payment.

l. *Were copies of the other carrier's evidence or explanation of benefits or payment submitted instead of the Provider's itemized bill?*
This usually indicates that the claimant has OHC.

m. *Does the system identify health plan carrier codes as evidence of OHC?*
If available, the Health Network information system should flag the claim for identification of OHC.

2. CalOptima Health or a Health Network shall not process a COB claim until the OHC adjudicates the claim or OHC is verified.

3. CalOptima Health or a Health Network shall process a COB claim only if an Explanation of Benefits (EOB) from the primary carrier is attached. The primary payer shall pay, reject, or apply the COB claim to the deductible.

4. If CalOptima Health or a Health Network receives a COB claim without proof of disposition (i.e., EOB or reject letter) from the OHC, CalOptima Health or a Health Network shall process the claim to the Provider using the appropriate denial reason code.

   a. Prior to January 1, 2022, a Provider should be directed to AEVS or the DHCS online eligibility portal for the OHC information. Beginning January 1, 2022, CalOptima Health or a Health Network shall include OHC information in the notification to the Provider when a claim is denied due to the presence of OHC. Notification should include but is not limited to:

      i. Name of the OHC provider; and

      ii. OHC contact or billing information.

E. Application of COB rules

1. If a Provider is paid a fee-for-service rate or negotiated contract fee, CalOptima Health or a

Health Network as the secondary payer, shall pay the difference between the amount paid by the OHC and the amount CalOptima Health or a Health Network would have paid in the absence of OHC.

a. CalOptima Health or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

b. The total of the payments issued by the OHC and CalOptima Health or a Health Network shall not exceed the normal plan benefits of CalOptima Health or a Health Network.

2. CalOptima Health or a Health Network shall not process claims unless the Provider presents proof that payment has been exhausted (other than OHC code of A or N). If a claim is submitted by a Provider for a Covered Service that is not covered by the OHC, CalOptima Health or a Health Network shall require an acceptable form of proof that all sources of payment have been exhausted, in the form of one (1) of the following:

a. A denial letter from the OHC for the service;

b. An EOB indicating that the service is not covered by the OHC; or

c. Documentation that the Provider has billed the OHC and received no response for ninety (90) days.

3. In the absence of proof of payment or denial of benefits as provided in Section III.E.2. of this Policy, the OHC plan may certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered, if applicable.

4. The Provider may bill CalOptima Health or a Health Network directly for payment for elective abortions not covered by TRICARE.

5. Regardless of the presence of OHC, CalOptima Health shall ensure providers do not refuse a covered service to a Member.

6. An OHC plan indicating coverage, other pre-paid health plan (PHP) or health maintenance organization (HMO), and other organizations not contracting with CalOptima Health or a Health Network to provide services, shall pay for services prior to reimbursement consideration by CalOptima Health or a Health Network for those services.

7. CalOptima Health or a Health Network shall pay for Covered Services that are not covered by a PHP or HMO if the claim is accompanied by a denial letter from the PHP or HMO.

8. If disputes require CalOptima Health or a Health Network to change contracting arrangements with Network Providers and/or Subcontractors that are deemed significant in accordance with DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations, CalOptima Health must meet notification and reporting requirements as specified in CalOptima Health Policies DD.2012: Member Notification of Change in the Availability or Location of Covered Services, and GG.1304: Continuity of Care During Health Network or Provider Termination.

F. A Provider shall submit a claim for a Member who is eligible for both Medicare and Medi-Cal to Medicare prior to billing CalOptima Health or a Health Network.

1. Medicare Part A (hospital only)

    a. If a Member has Medicare Part A only, a Provider shall submit a claim to Medicare for payment of the hospital charges and the facility or technical component fees of the ancillary charges.

    b. CalOptima Health or a Health Network shall pay Crossover Claims for the Medicare co- insurance and the annual deductible amounts not payable by Medicare.

    c. CalOptima Health or a Health Network shall pay the Medicare Part B component for inpatient services covered by Medicare.

    d. Medicare Part A Covered Services include, but are not limited to:

        i. Inpatient hospital care;

        ii. Psychiatric hospital care;

        iii. Skilled Nursing Facility (SNF) care;

        iv. Hospice care; and

        v. Respite care.

    e. A Provider shall submit a Medicare RAD with the claim for payment of Medicare Part B services to CalOptima Health or a Health Network for payment consideration.

2. Medicare Part B (outpatient physician services)

    a. If a Member has Medicare Part B only, a Provider shall submit a claim for inpatient hospital and facility charges up to the maximum allowed by CalOptima Health inpatient rates to CalOptima Health or a Health Network the primary payer for inpatient hospital and facility charges.

    b. A Provider shall submit a claim for physician services and professional component fees of the hospital ancillary charges (e.g., laboratory, radiology, therapy) to Medicare, the primary payer for all physician services and professional component fees of the hospital ancillary charges.

    c. CalOptima Health or a Health Network as the secondary payer, shall pay for the following:

        i. Medicare Part A component less the Medicare payment;

        ii. Medicare co-insurance; and

        iii. Annual deductible amount for Medicare Part B services.

    d. Medicare Part B Covered Services include, but are not limited to:

        i. Physician services;

        ii. Outpatient hospital treatments;

iii. Home health visits;

iv. Inpatient and outpatient medical services and supplies;

v. Blood supplies; and

vi. Other medical and health services, including but not limited to:

a) Transportation;

b) Home dialysis equipment;

c) Oral surgery;

d) Outpatient physical therapy;

e) Speech pathology;

f) Diagnostic radiology;

g) Radiation treatments;

h) Pathology and laboratory;

i) Psychology and occupational therapy (50% payable); and

j) Limited vision.

e. A Provider shall submit claims for Medicare Part B services to Medicare Part B carriers, in accordance with the EOMB.

f. A Provider shall submit claims for Medicare Part A services to Medicare Part A carriers, in accordance with the RAD.

3. Medicare Part A and Part B

a. If a Member has Medicare Part A and Part B, a Provider shall submit a claim to Medicare, the primary payer.

b. CalOptima Health or a Health Network, as a secondary payer, shall pay the amount billed for the Medicare co-insurance or annual deductibles for Medicare Part A, Medicare Part B, or Medicare Part A and Part B coverage.

4. If a Member who is entitled to Medicare is enrolled in a Medicare risk-sharing HMO plan, a Provider shall submit a claim to the HMO plan, the primary payer. CalOptima Health shall remain the secondary payer.

5. In no event shall CalOptima Health cost avoid or seek post payment recovery for the reasonable value of services from a Third Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

6. If CalOptima Health does not conduct post payment recovery for a Member with OHC, contractor must demonstrate to DHCS, upon request, that the cost of post payment recovery

exceeds the total contract revenues CalOptima Health projects it would receive from such activity.

G. Post-Payment Recovery Reporting

1. In accordance with DHCS requirements, CalOptima Health and a Health Network must engage in Post-Payment Recovery if OHC is discovered retroactively, or the Member had an OHC "A" indicator on the Medi-Cal eligibility record.

    a. Beginning April 1, 2021, Health Networks shall submit the monthly Post-Payment Recovery Template report (Attachment C) to CalOptima Health as follows:

        i. A Health Network shall submit a report for Post-Payment Recoveries by the third (3rd) calendar day of the month, or the first (1st) business day thereafter, if the third (3rd) falls on a weekend or holiday to CalOptima Health's FTP site. A Health Network shall submit the report using CalOptima Health's format and file naming convention.

        ii. CalOptima Health Information Services Department shall notify a Health Network of file acceptance or rejection no later than two (2) business days after receipt. CalOptima Health may reject a file for data completeness, accuracy, or inconsistency issues. If CalOptima Health rejects a file, a Health Network shall resubmit a corrected file no later than the fifth (5th) calendar day of the following month, or the first (1st) business day if the fifth (5th) falls on a weekend or holiday. Any resubmission after the fifth (5th) business day of the calendar month will be included in the subsequent month's process.

2. CalOptima Health will submit detailed information regarding recoveries to include CalOptima Health and Health Network data to DHCS in a monthly report utilizing DHCS secure File Transfer Protocol (sFTP) no later than the fifteenth (15th) of each month using the format and file naming convention required by DHCS.

3. If CalOptima Health or a Health Network initiate and completes Post-Payment Recovery within twelve (12) months from the date of payment of a service, CalOptima Health or the Health Network is entitled to retain all monies recovered.

    a. If CalOptima Health or a Health Network fails to complete Post Payment Recovery within twelve (12) months from the dates of payment for services but initiates an Active Repayment plan with a Provider or carrier that is agreed upon prior to and extends beyond twelve (12) months from the date of payment of a Covered Service, CalOptima Health or a Health Network is allowed to retain the recovered monies.

    b. CalOptima Health or a Health Network shall consider the Provider or carrier as having an Active Repayment plan if it has agreed to repay the liability but has not yet paid the full amount.

    c. On a monthly basis, CalOptima Health and a Health Network shall report all recovered OHC monies that are thirteen (13) months or older from the date of payment of a service to DHCS utilizing the monthly report (Attachment C).

    d. Beginning March 1, 2023, CalOptima Health and the Health Network shall include the check or Electronic Fund Transfer (EFT) control number under row "V", field name "Filer" for all related Transaction Control Numbers on the monthly report (Attachment C).

    e. Overpayments submitted prior to March 31, 2023, CalOptima Health and the Health

Network are not required to produce retroactive monthly reports (Attachment C) inclusive of the check or EFT control number.

f. CalOptima Health shall remit warrants, payable to DHCS, for all recovered monies that are thirteen (13) months or older from the date of payment by CalOptima Health or a Health Network of a service, unless the payment meets the criteria of an Active Repayment plan, to the following address:

Bank of America
P.O. Box 742635
Los Angeles CA 90074-2635

g. CalOptima Health shall recoup any amounts returned to DHCS on behalf of a Health Network in accordance with CalOptima Health Policy FF.1001: Capitation Payments.

h. DHCS Third Party Liability and Recovery Division (TPLRD) will conduct Post-Payment Recoveries and/or leverage its recovery contractor to initiate Post-Payment Recovery beginning the thirteenth (13th) month following the date of payment. Monies recovered by TPLRD will be retained by DHCS.

H. In accordance with DHCS requirements, COB reports maintained by CalOptima Health, and a Health Network shall display claim counts and dollar amounts of costs avoided and the amount of Post- Payment Recoveries by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. CalOptima Health and a Health Network shall make the reports available to DHCS upon request.

I. CalOptima Health or a Health Network may contract with a third-party vendor to recover any payments as described in Section II.G. of this Policy.

J. CalOptima Health and a Health Network shall have the right to obtain and release COB information and may do so without consent from the Member, or the Member's Authorized Representative. CalOptima Health and a Health Network shall require a Member to provide insurers with any information needed to make COB determinations, and to pay claims.

K. A Member shall satisfy the monthly Share of Cost (SOC) dollar amount for medical expenses prior to CalOptima Health certifying the Member to receive Medi-Cal benefits. Upon eligibility certification, the Medi-Cal host computer shall provide an Eligibility Verification Confirmation (EVC) number.

1. CalOptima Health and a Health Network shall reduce the reimbursement made to a Provider for services rendered to a Member with a SOC by the SOC amount.

2. CalOptima Health may require a Member with a SOC who has OHC to pay a deductible or a co-payment amount up to his or her SOC. A Provider may bill CalOptima Health or a Health Network the remaining balance of the deductible or co-payment amount. CalOptima Health shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less.

3. If a Member has no SOC obligations, a Provider may bill CalOptima Health or a Health Network for the co-payment or deductible amount. CalOptima Health or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less (up to the co-pay or deductible amount).

L. A Provider shall not bill or collect deductible or co-payment amounts from a Member, except as provided in Section III.K. of this Policy.

M. Medicare Crossover

1. CalOptima Health or a Health Network shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and Part B, as required by current regulations. CalOptima Health or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

2. CalOptima Health or a Health Network shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations.

N. CalOptima Health and a Health Network shall maintain, and on a monthly basis submit COB reports including, but not limited to, reports on Post-Payment Recovery for OHC, in accordance with Section III.E. of this Policy and applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance. CalOptima Health and its Health Networks shall retain such records for a period of at least ten (10) years after the termination of CalOptima Health's contract with DHCS.

IV. ATTACHMENT(S)

A. CMS-1500 Form
B. UB-04 Form
C. Post-Payment Recovery Template (Appendix B to Department of Health Care Service (DHCS) All Plan Letter 22-027: Cost Avoidance and Post Payment Recovery for Other Health Care Coverage)

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Coordination of Benefits Handbook, Business & Legal Resources (BLR), Copyright 2019
C. CalOptima Health Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
D. CalOptima Health Policy FF.1001: Capitation Payments
E. CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination
F. Title 22, California Code of Regulations (C.C.R), Division 3: Health Care Services, Chapter 2, Articles 12 & 15
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-027: Cost Avoidance and Post-Recovery for Other Health Coverage (Supersedes APL 21-002)
I. Welfare and Institutions Code §10022
J. Title 42 U.S. Code §1396a(a)(25)(D)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/06/2021	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2008	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2009	FF.2003	Coordination of Benefits	Medi-Cal
Revised	10/01/2016	FF.2003	Coordination of Benefits	Medi-Cal
Revised	06/07/2018	FF.2003	Coordination of Benefits	Medi-Cal
Revised	07/01/2019	FF.2003	Coordination of Benefits	Medi-Cal
Revised	12/03/2020	FF.2003	Coordination of Benefits	Medi-Cal
Revised	09/01/2021	FF.2003	Coordination of Benefits	Medi-Cal
Revised	02/01/2023	FF.2003	Coordination of Benefits	Medi-Cal
Revised	04/01/2024	FF.2003	Coordination of Benefits	Medi-Cal

IX. GLOSSARY

Term	Definition
Active Repayment	The action to repay the liability amount that has not yet been paid in full to the carrier or provider carrier.
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Coordination of Benefits	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Cost Avoidance	The practice of requiring Providers to bill liable third parties prior to seeking payment from the Medi-Cal program.
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, this Contract, and 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 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 this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 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);

Term	Definition
	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 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 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 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 APL 22-012.
Crossover Claim	A claim submitted for payment for a Medi-Medi 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 administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs.

Term	Definition
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.
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.
Other Health Coverage (OHC)	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.
Post-Payment Recovery	CalOptima Health's efforts to recover the cost of the services from other third-party payors responsible for the payment of a Member's health care services.
Provider	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.
Remittance Advice Detail (RAD)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Share of Cost (SOC)	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Skilled Nursing Facility (SNF)	Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.