Policy:	HH.1101
Title:	**CalOptima Health Provider Complaint**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 12/07/2023*
Effective Date:	03/01/1996
Revised Date:	12/07/2023
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health, Health Networks, and Third-Party Administrators (TPA) address and resolve contracted Provider Complaints, which include, but are not limited to, Provider Disputes, Appeals, and Grievances.

II. POLICY

A. CalOptima Health, Health Networks, and TPAs shall maintain a fast, fair, and cost-effective system to process and resolve contracted Provider Complaints, in accordance with applicable statutory, regulatory, and contractual requirements.

B. Providers shall utilize the Health Network and TPA grievance systems prior to filing a Complaint directly with CalOptima Health, in accordance with this Policy.

C. Multipurpose Senior Services Program (MSSP) Providers shall submit issues arising out of or related to the contract between CalOptima Health and a MSSP Provider, including but not limited to Disputes, claims, protests of awards or other contractual issues to the CalOptima Health Grievance and Appeals Resolution Services (GARS). GARS Department shall process the Complaints in accordance with the CalOptima Health MSSP-Department of Aging contract.

D. Complaints related to Appeals of Medical Necessity will be processed in accordance with CalOptima Health Policy HH.1102: Member Grievance

E. CalOptima Health, Health Networks, and TPAs shall promptly review and investigate Complaints and resolve them, in accordance with the timeframes set forth herein.

F. CalOptima Health, Health Networks, and TPAs shall not discriminate or retaliate against any Provider (including, but not limited to, terminating the Provider's contract) on grounds that such Provider filed a Complaint, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

G. CalOptima Health, Health Networks, and TPAs shall designate a principal officer to be primarily responsible for the maintenance, oversight, and analysis of trends and preparation of reports related to Provider Complaints as required by this Policy and applicable regulations.

H. CalOptima Health, Health Networks, and TPAs shall not impose a deadline for receipt of a Provider Complaint for a claims payment Dispute that is less than three hundred sixty-five (365) calendar days after the date of an action or, in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the time for contesting or denying the claim has expired.

I. If the Dispute relates to a demonstrable and unfair payment pattern by CalOptima Health, or CalOptima Health's Capitated Provider, neither CalOptima Health nor the Capitated Provider shall impose a deadline for the receipt of a Dispute that is less than three hundred sixty-five (365) calendar days from CalOptima Health's or the capitated Provider's most recent action, or in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the most recent time for contesting or denying claims has expired.

J. CalOptima Health, Health Networks, and TPAs shall not charge a Provider for the cost of processing a Provider Complaint. Notwithstanding the foregoing, CalOptima Health, Health Networks, and TPAs shall have no obligation to reimburse a Provider for any costs incurred in connection with utilizing the Provider Complaint process.

K. A Health Network and TPA shall make available to CalOptima Health and the Department of Health Care Services (DHCS) all records, notes, and documents regarding its Provider Complaint Resolution mechanism(s) and the Resolution of Provider Complaints.

L. CalOptima Health shall submit an annual report to DHCS that includes but is not limited to the total number of Providers who have utilized the Dispute mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream Subcontractors and a summary of the disposition of those Disputes.

M. CalOptima Health shall have the right to extend or stay the implementation of a decision or require a Health Network or TPA to delay or stay such a decision, in order to allow the affected Provider an opportunity to file a Complaint under this Policy.

N. A Provider who seeks to contest any decision made by CalOptima Health pursuant to this Policy is required to comply with CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, if applicable.

III. PROCEDURE

A. Submission of a Complaint

1. A Complaint shall contain the following:

a. Provider Dispute Resolution (PDR) Form, Appeal, or Dispute Letter and supporting documents.

b. Provider name and Provider Identification Number (PIN);

c. Contact information;

d. Claim number assigned to the original claim, if applicable;

e. Clear description of the Dispute;

f. Date of service;

g. Clear explanation of the basis upon which the Provider believes the action is incorrect;

h. If the Complaint involves a bundled group of multiple claims that are substantially similar, identification of the original claim number; and

i. If the Complaint involves a Dispute involving a Member or group of Members, the name(s) and identification number(s) and Claim numbers (if applicable) of the Member(s), a clear explanation of the Disputed item(s), includes the date(s) of service, and the Provider's position on the issue(s).

2. A Provider may submit an amended Provider Complaint within thirty (30) business days after the date of receipt of a returned Provider Complaint that is missing required information.

3. A Provider that has furnished Covered Services to a Member for which a Health Network is financially responsible, or is dissatisfied with any aspect of a Health Network's program, shall file a Complaint with that Health Network prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the Health Network's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

4. A Provider that has furnished Covered Services to a Member is dissatisfied with any aspect of a TPA's program, shall file a Complaint with that TPA prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the TPA's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

5. A Provider may file a Complaint with CalOptima Health as follows:

   a. The Provider has provided Covered Services to a Member for which CalOptima Health is financially responsible, or is dissatisfied with any aspect of CalOptima Health;

   b. The Provider has provided Covered Services to a Member for which a Health Network or TPA is financially responsible, is dissatisfied with a Complaint Resolution Letter received from the Health Network or TPA, as set forth in this Policy, and files within the following timeframes:

      i. Sixty (60) calendar days after the date of the Health Network's or TPA's Complaint Resolution Letter for Complaints related to Medical Necessity; or

      ii. One hundred eighty (180) calendar days after the date of the Health Network's Complaint Resolution Letter for all other types of Complaints.

6. A Provider may request additional time but must show good cause for an extension and provide supporting good cause documentation at the time of the request.

B. CalOptima Health, a Health Network or TPA Complaint Receipt and Resolution

1. Record of Complaint

a. CalOptima Health or Health Network shall enter into its Complaint tracking system each Complaint (whether or not complete) received and create an electronic or hard copy file.

b. A TPA shall track and maintain records of each Complaint (whether or not complete) it receives.

2. Acknowledgement of Complaint

a. CalOptima Health, Health Network or TPA shall acknowledge the receipt of a Complaint in paper form (whether or not complete) within fifteen (15) business days after the date of receipt by the office or department designated to receive Complaints.

b. CalOptima Health, Health Network or TPA shall acknowledge the receipt of a Complaint in electronic form (whether or not complete) within two (2) business days after the date of receipt by the office or department designated to receive Complaints.

3. Incomplete Complaints

a. CalOptima Health, a Health Network or TPA may return to a Provider any Complaint lacking the required information or information necessary to determine payer liability that is in the possession of the Provider and not readily accessible to CalOptima Health, Health Network or TPA.

b. The returned Complaint shall clearly identify, in writing, the missing reasonably relevant information or information necessary to determine payer liability. In no event shall CalOptima Health, a Health Network or TPA request the Provider to resubmit claim information that the Provider previously and appropriately submitted to CalOptima Health, the Health Network or TPA as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the Provider.

4. Investigation and Resolution of Complaints

a. Investigation

i. CalOptima Health, a Health Network or TPA shall promptly investigate a Complaint by consulting, as applicable, with the appropriate departments at CalOptima Health, the Health Network department(s), or TPA responsible for the services or operations that are the subject of the Complaint (e.g., Contracting, Utilization Management, Claims).

ii. The applicable CalOptima Health, Health Network or TPA department(s) shall investigate the factual matters that are the subject of the Complaint and shall report factual findings and a proposed resolution to CalOptima Health or Health Network Grievance staff within ten (10) business days after initial receipt of the Complaint.

iii. The applicable CalOptima Health, Health Network or TPA department shall use the Complaint Referral and Investigation Request Form, or a similar form, to report findings and proposed resolutions to the CalOptima Health or Health Network Grievance staff, as set forth in this Policy.

iv. CalOptima Health may request that the Provider submit any written materials relevant to the Provider's Complaint.

v. If the Provider is appealing a Health Network or TPA Complaint Resolution Letter, CalOptima Health shall review the Health Network or TPA Complaint file.

b. Resolution

i. CalOptima Health, a Health Network or TPA shall resolve and issue a Complaint Resolution Letter for each Complaint it receives within forty-five (45) business days after the date of receipt of the Complaint or amended Complaint, in accordance with applicable laws, including those regulatory provisions identified in Title 28, California Code of Regulations, §1300.71.38(f).

ii. The Complaint Resolution Letter shall describe the pertinent facts of the Complaint, the reasons for a CalOptima Health, Health Network or TPA determination, and applicable Provider Appeal rights, including the following:

a) For Complaints related to Medical Necessity, the right to Appeal the determination to the GARS Department within sixty (60) calendar days after the date of the Health Network or TPA Complaint Resolution Letter; or

b) For other Complaints, the right to request a Legal Claim pursuant to CalOptima Health CalOptima Health Policy AA.1217: Legal Claims and Judicial Review.

c. Implementation of Complaint Resolution

i. CalOptima Health and its Health Networks or TPA shall take immediate action to implement the determinations set forth in a Complaint Resolution Letter.

ii. If the Complaint or amended Complaint is determined in whole or in part in favor of the Provider, the Health Network shall pay:

a) Any outstanding monies that it determines to be due; and

b) All interest and penalties required within five (5) business days after the date of the Complaint Resolution Letter, pursuant to CalOptima Health Policy HH.2015: Health Networks Claims Processing.

iii. Accrual of interest and penalties for the payment of any resolved Complaints shall commence on the day following the expiration of the time for reimbursement.

a. Resolution of Complaints submitted by Provider to CalOptima Health

i. GARS staff shall review the factual findings, proposed Resolution, and any other relevant information, and shall issue a decision with respect to the Complaint or amended Complaint, in accordance with CalOptima Health Policy HH.1109: Complaints Decision Matrix.

ii. Within forty-five (45) business days after receipt of the Complaint or amended Complaint, GARS staff shall send a Complaint Resolution Letter to the Provider.

b. Implementation of Resolution by CalOptima Health

i. CalOptima Health may take immediate action, or, as appropriate, require that a Health Network or TPA take immediate action to implement the decision set forth in CalOptima Health's Complaint Resolution Letter.

ii. If the Complaint is a payment-related issue, and CalOptima Health determines that a Health Network is financially responsible, the Health Network shall make payment in the amount specified by CalOptima Health to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The Health Network shall send written proof of payment to GARS staff.

iii. If the Health Network does not pay the claim as required by this Policy, CalOptima Health shall pay the claim on behalf of the Health Network and shall deduct from the Health Network's capitation payment the amount paid on behalf of the Health Network plus the greater of a two hundred fifty-dollar ($250.00) administrative fee or ten percent (10%) of the amount paid.

iv. If the Complaint is a payment-related issue, and CalOptima Health determines that a TPA is financially responsible, the TPA shall make payment in the amount specified by CalOptima Health to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The TPA shall send written proof of payment to GARS staff.

C. CalOptima Health Responsible Staff

1. The GARS Director shall have primary responsibility for the maintenance of the Provider Complaint process.

2. The CalOptima Health Chief Operations Officer shall have primary responsibility for the oversight and review of operations, and for identifying any emergent patterns of Complaints to improve administrative capacity, provider relations, claims payment procedures, and Member care.

D. CalOptima Health Monitoring

1. CalOptima Health, Health Networks and TPAs shall continuously monitor for trends and systemic issues. If any trends are identified, a performance or corrective action plan shall be developed to address the trend. CalOptima Health shall monitor for performance improvement.

2. On an annual basis, CalOptima Health shall assess all Disputes received to identify any overall trends or systemic issues and identify the root cause. Based on this annual assessment, CalOptima Health shall develop a plan to address each trend or system issue identified. This report shall be submitted annually to DHCS.

3. If CalOptima Health determines that a Health Network has failed to comply with any requirements of this Policy, CalOptima Health may take appropriate action, including, but not limited to, imposing Corrective Action Plans or Sanctions against the Health Network under CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions.

4. CalOptima Health shall monitor a TPA in accordance with CalOptima Health policy.

E. Notices, Records, and Reports

1. Notice to Providers of Complaint Procedure

    a. CalOptima Health and Health Networks shall include a reference to this Policy in each Provider contract.

    b. CalOptima Health and Health Networks shall notify Non-Contracted Providers of the availability of a Provider Complaint process. This notification may be satisfied through the Health Network's routine Provider communication processes, including, but not limited to, newsletters, bulletins, policy and procedure manuals, remittance advice notices, and Websites.

2. Records

    a. CalOptima Health, Health Networks, and TPAs shall maintain written records of each Complaint, including at least the following information: date of receipt, Provider's name; name(s) of staff who received the Complaint and is designated as the contact person, description of the Complaint, medical records, documents, evidence of coverage and other relevant information upon which CalOptima Health, Health Networks, and TPAs relied on in reaching its decision and disposition for ten (10) years.

    b. CalOptima Health, Health Networks and TPAs shall retain written records of each Complaint, including copies of all Complaints and responses thereto, including all notes, documents, and other information upon which CalOptima Health, the Health Network, or TPA relied upon to reach its decision for a period of ten (10) years following the termination of their contracts with CalOptima Health. A Health Network and TPA shall make records for the last two (2) years available on-site.

    c. A Health Network and TPA shall make available warehoused or stored records within five (5) business days after a request for such records by CalOptima Health or DHCS.

3. Reporting Provider Complaint Activity

    a. At a maximum, on a monthly basis, a Health Network shall submit to the CalOptima Health Audit & Oversight Department.

    b. Each claim within a Complaint that has bundled substantially similar claims Disputes must be listed separately as individual Complaints (including original claim numbers) on the report.

    c. A Principal Officer shall sign the report certifying that the report is true and correct, to the best of their knowledge and belief.

F. Other Provider Rights. In addition to any rights set forth in this Policy and allowed by law, a Provider also has the following rights:

1. Claim Resubmission. Prior to filing a Complaint related to payment of a claim, a Provider may resubmit the claim to the Health Network or TPA, as appropriate, in accordance with the applicable Health Network, or TPA, claim resubmission policy.

2. Provider's Right to Hearing

    a. Request for Hearing

        i. A Provider that Disputes recoupment of funds based upon audit findings of overpayments, the imposition of Sanctions or penalties, or suspension or termination of the Provider's participation in CalOptima Health, a Health Network or TPA, may request a hearing before the Provider Grievance Review Panel if:

            a) The Provider has received a Complaint Resolution Letter from CalOptima Health; or

            b) The Provider has received a Complaint Resolution Letter from a Health Network or TPA and pursues a hearing in lieu of filing a written Complaint to CalOptima Health under Section III.A of this Policy.

        ii. No other hearings are provided under this Policy.

        iii. A Provider may submit to GARS staff a written request for hearing within fifteen (15) calendar days after CalOptima Health's, a Health Network's or TPA's issuance of a Complaint Resolution Letter. The written request shall set forth with specificity the reasons for the hearing, including if the Provider challenges:

            a) The factual basis of the decision, and if so, which facts in particular;

            b) The legal basis for the decision; or

            c) The reasonableness of the decision, Sanctions, or penalties imposed.

    b. Acknowledgment of Request for Hearing

        i. Upon receipt of a request for hearing, CalOptima Health shall set a hearing date to be held within thirty (30) calendar days after receipt of the request.

        ii. CalOptima Health shall send to the Provider a Hearing Acknowledgment Letter within five (5) calendar days after the Provider's request for a hearing, setting forth the date, time, and location of the hearing.

    c. Hearing

        i. The purpose of the hearing is to afford the Provider an opportunity to contest the factual or legal basis of the decision, or the reasonableness of the decision.

        ii. The hearing is intended to be informal in nature. Formal rules of evidence and discovery do not apply. There shall be no cross-examination of witnesses. The Provider, CalOptima Health, Health Network, and TPA, as appropriate, shall have the opportunity to present oral testimony and documentary evidence.

        iii. The Provider Grievance Review Panel shall select a hearing officer to preside at the hearing. The hearing officer may, from time to time, establish hearing guidelines governing the hearing procedure. The hearing officer may ask questions to any party at the hearing and shall ensure proper decorum at the hearing.

iv. The hearing officer may cause a recording of the hearing to be made, either by tape recording or providing a court reporter service.

v. After the conclusion of the hearing, the Provider Grievance Review Panel may adopt, reject, or modify, in whole or in part, the actions addressed at the hearing. The hearing officer shall send the Provider Grievance Review Panel's written decision to the Provider, Health Network, and TPA, as appropriate, within forty-five (45) calendar days after the close of the hearing. The decision shall be effective on the date issued by the hearing officer.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services
B. CalOptima Health Contract with the California Department of Aging (CDA)
C. CalOptima Health Contract for Health Care Services
D. California Health and Safety Code, § 1367(h)
E. California Welfare and Institutions Code § 14094.15(d)
F. Title 28, California Code of Regulations (C.C.R.), §1300.71.38
G. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review
H. CalOptima Health Policy FF.1001: Capitation Payments
I. CalOptima Health Policy HH.1102: Member Grievance
J. CalOptima Health Policy HH.1109: Compliant Decision Matrix
K. CalOptima Health Policy HH.2002: Sanctions
L. CalOptima Health Policy HH.2005: Corrective Action Plan
M. CalOptima Health Policy HH.2015: Health Networks Claims Processing
N. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/30/2014	Department of Health Care Services (DHCS)	Approved as Submitted
03/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2022	Department of Health Care Services (DHCS)	File and Use
01/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/02/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
09/23/1997	Regular Meeting of the CalOptima Board of Directors
02/01/2005	Regular Meeting of the CalOptima Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1996	EE.1113	CalOptima Contractor Grievance Policy and Procedure	Medi-Cal
Revised	09/01/1998	EE.1113	CalOptima Provider Complaint	Medi-Cal
Revised	11/01/2000	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	08/01/2001	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2003	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2004	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	02/01/2005	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2010	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2013	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	09/01/2013	HH.1101	CalOptima Provider Complaint	Medi-Cal
Reviewed	09/01/2014	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	07/01/2016	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	08/01/2018	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	10/01/2019	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	10/01/2022	HH.1101	CalOptima Health Provider Complaint	Medi-Cal
Revised	01/01/2023	HH.1101	CalOptima Health Provider Complaint	Medi-Cal
Revised	12/07/2023	HH.1101	CalOptima Health Provider Complaint	Medi-Cal

IX. GLOSSARY

Term	Definition
Appeal	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).
Capitated Provider	Providers that are reimbursed on a capitation basis.
Complaint	A dispute from a provider, regardless of contract status, related to any action or inaction by CalOptima Health, a Health Network or any delegated entity.
Complaint Resolution Letter	A written statement explaining the disposition of an Appeal or Complaint based on a review of the facts, relevant information, and documentation.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Service	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'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 Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
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.
Dispute	A claims payment dispute regarding an amount paid that is less than the expected rate.
Grievance	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.
Health Networks	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.
Medically Necessary or Medical Necessity	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 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 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.
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.
Multipurpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with disabilities as an alternative to nursing facility placement.
Network Provider	A Provider that subcontracts with CalOptima Health for the delivery of Medi-Cal Covered Services.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Principal Officer	Means a president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Provider Complaint	The general term used to identify all provider filed request for review, and expressions of, dissatisfaction with any aspect of CalOptima Health or its Health Networks or TPAs. This includes Appeals, Disputes, and Grievances.
Provider Grievance Review Panel	A committee consisting of management level subject matter experts who will review and reach a determination for all requested hearings. The individuals on this panel will vary by case review.
Resolution	The appeal or complaint has reached a final conclusion with respect to the Provider's submitted appeal or complaint.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.
Subcontractor	An individual or entity who has a Subcontract with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS.
Third Party Administrator (TPA)	An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.