Policy:	GG.1507
Title:	**Notification Requirements for Covered Services Requiring Prior Authorization**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 05/15/2024*
Effective Date:	02/01/1997
Revised Date:	05/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes guidelines by which CalOptima Health, and its Health Networks shall notify a Member, Member's Authorized Representative, Prescribing Practitioner, and Primary Care Practitioner (PCP), when a request for Prior Authorization of a Covered Service is processed.

II. POLICY

A. CalOptima Health and its Health Networks shall process and authorize requests for Prior Authorization in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

B. For Members enrolled in OneCare, CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied.

1. Confirm the process of diagnoses or other medical criteria that are in the basis for coverage determinations for the specific item or service;

2. Basic benefits item or service is Medically Necessary; or

3. Supplemental benefits service or benefit is clinically appropriate.

C. CalOptima Health or a Health Network shall notify a Member, the Member's Authorized Representative, Prescribing Practitioner, and PCP, as appropriate, if:

1. CalOptima Health or the Health Network denies, modifies, or delays a request for Prior Authorization for a Covered Service requiring Prior Authorization; or

2. CalOptima Health or the Health Network terminates a previously approved Covered Service.

D. CalOptima Health or a Health Network may not deny, reduce, suspend, or terminate services or treatments without providing adequate notice within applicable legal timeframes.

1. CalOptima Health or a Health Network must calculate the deadline for a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative

formats, to take action from the date of adequate notice, including all deadlines for Appeals, and Aid Paid Pending.

2. Should CalOptima Health or the Health Network fail to provide adequate notice to a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within applicable federal or state timeframes, and in accordance with CalOptima Health Policies: DD.2002: Cultural and Linguistic Services, and MA.4002: Cultural and Linguistic Services, then the Member is deemed to have exhausted CalOptima Health's internal Appeal process, and may immediately request a State Hearing, in accordance with CalOptima Health Policy HH.1108: State Hearings Process and Procedures. CalOptima Health and its Health Networks are prohibited from requesting dismissal of a state hearing on the basis of failure to exhaust the CalOptima Health and its Health Networks internal appeal processes in such cases.

E. CalOptima Health or a Health Network shall notify a Member, the Member's Authorized Representative, Prescribing Practitioner, and PCP, as appropriate, with a written Notice of Action (NOA), applicable for Medi-Cal Members; or Coverage Decision Letter applicable to OneCare Members.

F. NOAs and Coverage Decision Letters, shall comply with contractual, State, and Federal requirements, as found in section 51014.1 of Title 22 of the California Code of Regulations, CalOptima Health's Contract for Health Care Services with its Health Networks, Department of Health Care Services (DHCS) All Plan Letter 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates, and in the Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual – Chapter 4 and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

G. CalOptima Health or a Health Network shall send a NOA or Coverage Decision Letter in a timely manner, and a culturally and linguistically appropriate manner in accordance with the timelines set forth in Attachments A and B to this Policy, and in compliance with the language requirements of CalOptima Health Policies DD.2002: Cultural and Linguistic Services, and MA.4002: Cultural and Linguistic Services.

1. In providing NOAs and Coverage Decision Letters, CalOptima Health shall abide by the timing requirements for Medi-Cal service requests contained in Attachment A, and the requirements for Medicare (OneCare) service requests contained in Attachment B.

2. As provided in Attachments A and B, the timing in which NOAs and Coverage Decision Letters must be sent to the Member and providers shall be determined by the nature of the request (*e.g.*, expedited, routine) based on the Member's condition and may be affected by whether the provider submits all necessary information with the request.

H. CalOptima Health shall not be required to send a NOA or Coverage Decision Letter if CalOptima Health approves a drug identical in chemical composition, dosage, and bioequivalence of a requested drug (*i.e.*, when a generic drug is substituted for the brand name drug).

I. A Health Network may delegate the notification requirements set forth in this Policy to a subcontracting medical group. In accordance with delegation oversight requirements, Health Networks shall be responsible for complying and ensuring subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and CalOptima Health policies and procedures related to notification requirements for Covered Services requiring Prior Authorization.

J. Pursuant to requirements established by DHCS, CMS, and the National Committee on Quality Assurance (NCQA), and as reflected in the DHCS NOA and CMS Coverage Decision Letter, a qualified CalOptima Health Medical Director shall review all medical denials, delays, and modifications for Medically Necessity, or benefit coverage in Prior Authorizations, concurrent reviews, and terminations.

III. PROCEDURE

A. CalOptima Health and a Health Network shall utilize the template NOA provided by DHCS or CMS, or equivalent language in the NOA or Coverage Decision Letter.

1. The NOA and Coverage Decision Letter shall include information on accessing interpretive services in Threshold Languages and information regarding accessing Teletype/Teletypewriter (TTY) services.

2. The NOA and Coverage Decision Letter shall inform a Member of the Member's right to file for an Appeal for services covered by Medi-Cal, or an Independent Review for services covered by Medicare, upon receiving a notification of denial, delay, modification, reduction, suspension, or termination of Covered Services.

3. For Medi-Cal Covered Services, the NOA shall:

a. Contain a statement of the action CalOptima Health is taking on the request;

b. Describe the specific reason(s) for the decision in easy to understand language, and provide a reference and explanation of the CalOptima Health Prior Authorization guidelines or specific regulations on which the decision was based;

i. For decisions not based on Medical Necessity, the NOA shall provide a clear and concise explanation of the reasons for the decision.

ii. Decisions to deny services cannot be solely based on requested codes being listed as non-benefits (*i.e.*, in the Medi-Cal Treatment and Authorization (TAR) and Non-Benefit list of codes), and other reasons for the denial must be included in the NOA (*i.e.*, services were determined to be not Medically Necessary and/or did not meet other criteria considered).

c. Define how the Member, Prescribing Practitioner, or PCP can obtain a copy, free of charge, of the actual benefit provision, guideline, protocol, or other criteria on which the denial decision was based;

d. Describe the clinical reasons for the decision and explain how the Member's condition does not meet criteria or guidelines;

e. Inform the Prescribing Practitioner or PCP of the availability of an appropriate Practitioner to discuss the decision and provide contact instructions, including the name and direct telephone number of the healthcare professional responsible for the denial, delay, or modification to allow the Prescribing Practitioner or PCP to easily contact the healthcare professional responsible for the denial, delay, or modification;

f. Include a "Your Rights" attachment that contains general information regarding the Member and Prescriber Practitioner's or PCP's standard and expedited Appeal rights, an explanation of the Appeal process, and instructions on how to submit an Appeal, an

explanation and instructions for the State Hearing process, and the right and how to request continuation of Covered Services, along with the nondiscrimination notice and language assistance taglines;

g. Explain that the Member, Prescribing Practitioner or PCP can provide written comments, documents, or other information to Appeal the denial; and

h. If CalOptima Health or a Health Network terminates an authorization for an ongoing service, CalOptima Health or a Health Network shall send the NOA at least ten (10) calendar days prior to the date of the termination.

4. For Medicare covered services, the Coverage Decision Letter shall:

a. Include a specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable plan policy (*e.g.*, Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;

b. Provide information regarding a Member's right to Appeal and the right to appoint a representative to file an Appeal on the Member's behalf;

c. For service denials, include a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process;

d. Explain that the Member has a right to submit additional evidence in writing or in person; and

e. Include an explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

5. CalOptima Health or the Health Network must provide auxiliary aids and services to a family member, friend, or associate of a Member if required by the ADA, including if the individual is identified as the members' Authorized Representative, or is someone with whom it is appropriate for CalOptima Health or the Health Network to communicate.

a. Communication needs must be accommodated for all qualified Members with disabilities, including Authorized Representatives, and be prepared to facilitate alternate format requests for Braille, audio format, large print (no less than 20-point Arial font), and acceptable electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services, and MA.4002: Cultural and Linguistic Services.

6. CalOptima Health or a Health Network shall communicate to the Prescribing Practitioner or PCP, a decision to approve, modify, or deny an authorization prior to, or concurrent with the provision of a Covered Service within twenty-four (24) hours of the decision.

B. Continuation of Benefits Pending an Appeal for Medi-Cal Covered Services

1. If CalOptima Health or a Health Network terminates an authorization for an ongoing service, the Member has a right to request continuation of benefits for Medi-Cal Covered Services by

filing an Appeal within ten (10) calendar days after the date of the mailing of the NOA or Coverage Decision Letter, as applicable, or the last date on which services were authorized under the immediately preceding authorization, whichever is later, in accordance with CalOptima Health Policy GG.1510: Appeal Process.

2. Upon notification that the Member timely requested an Appeal, CalOptima Health or a Health Network shall authorize continuing services from the date that the previous authorization expired.

3. The authorization shall not be at a level of service greater in amount, or frequency, than approved by the immediately preceding authorization.

4. The authorization period shall be determined according to the following:

   a. Acute Care Continuing Services: The authorization shall be valid until the date an Appeal or State Hearing decision is rendered, the date on which an Appeal is withdrawn or closed, the date the treating Practitioner documents that the Member is ready for a lower level of care, or the date of discharge, whichever is earliest.

   b. Non-Acute Continuing Services: The authorization shall be valid up to and including the date the Continuing Services were requested by the treating Practitioner, the date an Appeal or State Hearing decision is rendered, or the date on which the hearing Appeal is withdrawn or closed, whichever is earliest.

5. If the Member requests a continuation of services more than ten (10) calendar days after the date of the mailing or hand delivery of the NOA or Coverage Decision Letter, or after the last date on which services were authorized under the immediately preceding authorization, whichever is later, CalOptima Health or a Health Network shall send the Member a Notice of Appeal Resolution (NAR) or Coverage Decision Letter stating that the request for continued services is denied.

C. Aid Paid Pending a State Hearing for Medi-Cal Covered Services

1. To receive continuing service, a Member shall request a State Hearing within ten (10) calendar days after the date of the mailing of the NAR or Appeal resolution Coverage Decision Letter, or the last date on which services were authorized under the immediately preceding authorization, whichever is later.

2. Upon timely filing a State Hearing requesting Aid Paid Pending, a Member may be eligible for continuation of benefits in accordance with Section III.B. of this Policy.

D. File copies of all notification letters shall be retained in the medical management system and the Member's Medical Record, in accordance with CalOptima Health Policy GG.1603: Medical Record Maintenance.

E. CalOptima Health shall monitor Health Network compliance with this Policy in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

A. Timeframes for Medi-Cal Decisions and Notifications
B. Timeframes for OneCare Decisions and Notifications

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Applicable Integrated Plan
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 DD.2002: Cultural and Linguistic Services
E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy GG.1510: Appeal Process
G. CalOptima Health Policy GG.1603: Medical Record Maintenance
H. CalOptima Health Policy GG.1619: Delegation Oversight
I. CalOptima Health Policy MA.4002: Cultural and Linguistic Services
J. CalOptima Health Utilization Management Program
K. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual – Chapter 4 and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
L. Department of HealthCare Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice, and "Your Rights" Templates (supersedes APL 17-006)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection for Members with Visual Impairments
O. Medi-Cal Provider Manual – Part 1: Medi-Cal Program and Eligibility, TAR Overview. Revised: 01/15/2021
P. Title 28 of the California Code of Regulations (CCR) 1300.68(a)(1) and (2); and 42 CFR 438.400(b).
Q. Title 42, Code of Federal Regulations (CFR) §§ 422.138(a) and (b)(1-3)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/01/2013	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
08/17/2022	Department of Health Care Services (DHCS)	File and Use
05/19/2023	Department of Health Care Services (DHCS)	File and Use
05/07/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTIONS

Date	Meeting
03/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/1997	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/1997	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/1999	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	05/01/1999	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2003	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	10/01/2003	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	07/01/2007	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2013	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	07/01/2017	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	10/01/2020	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	03/03/2022	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	08/01/2022	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	09/01/2022	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare
Revised	01/01/2023	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare
Revised	05/01/2023	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare
Revised	05/01/2024	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Any of the following actions: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals. 6. For a resident of a rural area with only one managed care plan, the denial of the Member's request to obtain services outside the network. 7. The denial of a Member's request to dispute financial liability.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.

Term	Definition
Authorized Representative/Legal Representative	Medi-Cal: 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. OneCare: An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process and does not provide broad legal authority to make another individual's healthcare decisions.
CalOptima Health	For purposes of this policy, CalOptima Health means CalOptima Health Direct, including CalOptima Health Direct-Administrative and CalOptima Health Community Network (CHCN).
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Coverage Decision Letter	OneCare: A written notice required to a Member, when, as a result of an Integrated Organization Determination under 42 CFR 422.631, reduce, stop, suspend or deny in whole or in part, a request for a service/item or a request for payment of a service/item the Member has already received.
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 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,

Term	Definition
	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); 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;

Term	Definition
	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 contract with the Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of 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. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	For purposes of this policy, 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.

Term	Definition
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.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: 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 a CalOptima Health program.
Notice of Action (NOA)	Medi-Cal: A formal letter from CalOptima Health informing a Member of an "Adverse Benefit Determination."
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), Speech and Language Therapist furnishing Covered Services.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.

Term	Definition
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 Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical 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.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Prior Authorization Notification	For the purposes of this policy, a written notification giving prior approval to provide and receive reimbursement for a Covered Service, equipment, or supplies.
State Hearing	Medi-Cal: A hearing with an Administrative Law Judge to resolve a Member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.
Threshold Language	Medi-Cal: The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS. OneCare: A Threshold Language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.