Policy:	GG.1503
Title:	**CalOptima Health Hospice Coverage, Notification and Validation Requirements**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 09/24/2024*
Effective Date:	06/01/2001
Revised Date:	09/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

To clarify CalOptima Health's hospice benefit coverage, Notification and Validation requirements.

II. POLICY

A. CalOptima Health and its Health Networks shall be responsible for ensuring the provision of Hospice Care services for Terminally Ill Members who meet the requirements outlined in Section II.C of this policy. CalOptima Health and its Health Networks shall be responsible for the following, in accordance with Health Network-specific Division of Financial Responsibilities (DOFR):

1. The following Hospice Care services as determined by the Member's enrollment in a CalOptima Health program:

CalOptima Health Program	**CalOptima Health Hospice Care Services Responsibility**				
	Routine Home Hospice (Rev Code 651)	**Continuous Home Care (Rev Code 652)**	**Respite Care (Rev Code 655)**	**General Inpatient Care (Rev Code 656)**	**SNF: Room and Board (Rev Code 658)**
Medi-Cal	Yes	Yes	Yes	Yes	Yes
OneCare	No*	No*	No*	No*	Yes
CalOptima Health Direct Administrative (COD-A) Dual eligible Member	No*	No*	No*	No*	Yes
*Billed to Medicare Fee-For-Service/Original Medicare.					

2. A Member who receives services under the Whole Child Model (WCM) program who elects Hospice Care services shall continue to receive Medically Necessary treatment services for any other California Children's Services (CCS)-eligible Conditions; and

3. Room and Board coverage for a Member residing in a Long-Term Care (LTC) facility through the Medi-Cal benefit and receiving Hospice Care services.

B. Medicare Hospice Benefit Eligibility Requirements:

1. Medicare Part A (Hospital Insurance) coverage;

2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease runs its normal course);

3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and

4. The Member or Authorized Representative signs a statement choosing Hospice Care instead of other Medicare-covered treatments for the Terminal Illness and related conditions.

C. Medi-Cal Hospice Benefit Eligibility Requirements:

1. Medi-Cal is the Member's primary inpatient/hospital coverage;

2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease is to run its normal course);

3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and

4. The Member or Authorized Representative signs a statement choosing Hospice Care instead of other Medi-Cal covered treatments for the Terminal Illness and related conditions.

5. A Member younger than twenty-one (21) years of age, and certified by a physician as having a life expectancy of six (6) months or less, may elect to concurrently receive hospice services and palliative care in addition to curative treatment of the hospice-related diagnosis in accordance with CalOptima Health Policy GG.1550: Palliative Care Services.

D. A Member may elect to receive hospice benefits for two (2) election periods consisting of ninety (90) calendar days each and an unlimited number of subsequent periods of sixty (60) calendar days each. At any time during an election period, a Member may elect to revoke or modify Hospice Care. A Member or Member's Authorized Representative must file a signed statement with the Hospice Provider revoking the Member election for the remainder of the election period. A change from one designated Hospice Provider to another is not considered a revocation of the hospice election.

E. Four (4) levels of Hospice Care:

1. Routine Home Care;

2. Continuous Home Care;

3. Respite Care; and

4. General Inpatient Care.

F. Notification and Validation Requirements

1. A Member with Medicare A and B coverage living in the community (not in an LTC facility) shall be exempt from all Notification requirements related to coverage of professional services for hospice.

2. For OneCare, and Medi-Cal primary Members, the Hospice Provider shall notify and coordinate with CalOptima Health or the Member's assigned Health Network for covered healthcare services that are unrelated to the Terminal Illness.

3. Medi-Cal primary Members may access Hospice Care within twenty-four (24) hours of Notification of Hospice request. CalOptima Health shall not require prior authorization for Hospice Care services under Routine Home Care, Continuous Home Care, and Respite Care levels of Hospice Care. A Hospice Provider shall provide documentation to support these levels of care.

Level of Care	**Notification**	**Validation**
Routine Home Care	Notification Required – within thirty (30) calendar days of start of service.	Required for each certification period – two (2) ninety (90) calendar day periods, then unlimited 60 calendar day periods. Certification of Terminal Illness documentation must be presented prior to the expiration of the current certification period.
Continuous Home Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate the Member has received a minimum of eight (8) hours of direct care within a twenty-four (24)-hour period.
Respite Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate that Member received Respite Care. Retroactive approval will be granted on an intermittent, non-routine basis, up to five (5) consecutive days at a time.
General Inpatient Care	Authorization Required. Notification required within one (1) business day but no more than seven (7) calendar days of start of service.	Required – authorization will be granted in seven (7) day intervals upon Validation of medical needs justification
Service Intensity Add-on	Notification required within twenty-four (24) hours after Member's death	Submit documentation to validate the Member has received service provided by a Social Worker or Registered Nurse during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day up to seven (7) days

Level of Care	Notification	Validation
Special Physician Services	Notification required within thirty (30) calendar days of start of service	Submit documentation to validate the Member has received services provided by a physician specializing in services that meets the Member's specific needs, and the hospice employed physician is unable to meet the Member's needs, and limited to one (1) visit per day per Member

4. For Medi-Cal primary Members requiring General Inpatient Care, planned or unplanned admissions, a Hospice Provider shall submit an authorization request for hospice services within the next business day or no later than seven (7) calendar days after the start of services. If a hospice provider does not provide adequate clinical documentation or documents do not substantiate the need for General Inpatient Care, the CalOptima Health Medical Director may reduce the Level of Care to Routine Home Care. Following such a decision, the Hospice Provider shall have the right to appeal the Level of Care decision, in accordance with CalOptima Health Policies GG.1510: Appeal Process, GG.1814: Appeal Process for Long-Term Care Facility, MA.9003: Standard Pre-Service Appeal., MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9015: Standard Integrated Appeals.

5. Notification for Routine Home Care during the last seven (7) days of life – Service Intensity Add-On (SIA)

    a. If a Medi-Cal primary Member was determined to be in the last seven (7) days of life, the Hospice Provider shall notify CalOptima Health within twenty-four (24) hours of Member's expiration and request SIA when the following criteria are met:

        i. The day was a Routine Home Care Level of Care day;

        ii. The days occurred during the last seven (7) days of life and the Member expired;

        iii. The service was provided in-person by a Social Worker or a Registered Nurse; and

        iv. The SIA number of hours (in fifteen (15) minute increments) of service provided by a Registered Nurse or Social Worker during the last seven (7) days of life met a minimum of fifteen (15) minutes and a maximum of four (4) hours per day, up to seven (7) days, not to exceed a combined maximum of 112 units.

6. If a CalOptima Health Member, regardless of CalOptima Health program enrollment, utilizes Hospice Care services in a LTC facility, the Hospice Provider shall submit Notification for facility services (room and board) to the CalOptima Health Long Term Services and Supports (LTSS) Department.

    a. The Hospice Provider shall submit a Notification for hospice services for a CalOptima Health Medi-Cal Member within thirty (30) calendar days after the start of services for the following Hospice Level of Care services utilizing the Hospice Validation / Notification Form (HVNF) to include the dates of service along with documentation of services provided:

        i. Continuous Home Care;

ii. Routine Home Care;

iii. Respite Care; and

iv. Special physician services.

G. Member requests to change a Hospice Provider, the current Hospice Provider shall provide a transferring Member with a transfer summary signed by the Member's hospice physician. The transfer summary shall include, but not be limited to the following information:

1. Member's diagnosis;

2. Pain treatment, and management;

3. Medications;

4. Medical treatments;

5. Dietary requirement;

6. Known allergies;

7. Treatment plan; and

8. Previous hospice benefit period information.

H. A Member who moves his or her legal residence outside of Orange County must disenroll from CalOptima Health. Hospice Providers shall provide transferring Members with a transfer summary which shall be signed by the physician. Upon enrollment in the new county, a "change in designated hospice" must be initiated. This may be done only once per election period.

I. CalOptima Health and its Health Networks, in accordance with the active DOFR, shall pay the standard per diem set by Medi-Cal to all Hospice Providers for Medi-Cal primary Members. For a Member who has Medicare and Medi-Cal residing in an LTC facility, the Hospice Provider shall bill Medicare for the hospice services and bill CalOptima Health for room and board.

J. CalOptima Health and its Health Networks, in accordance with the active DOFR, shall pay two (2) different Routine Home Care rates for Medi-Cal primary Members, based upon the following:

1. Routine Home Care high rate: defined as day one (1) to sixty (60) of an episode; and

2. Routine Home Care low rate: defined as day sixty-one (61) and beyond.

3. For a Member who is discharged and readmitted to hospice within sixty (60) calendar days of that discharge, the Member's hospice days will continue to follow the patient and count toward the Member days for the receiving hospice in the determination of whether the receiving Hospice Provider may be considered at the high or low Routine Home Care rate, upon hospice election.

4. For a Member who has been discharged from Hospice Care for more than sixty (60) calendar days, a new election to Hospice will initiate a reset of the Member's sixty (60) calendar day window and it is considered at the Routine Home Care high rate upon the new Hospice election.

K. Special Physician Services for Medi-Cal primary Members

1. A Hospice Provider shall submit a Notification with medical justification including diagnoses related to the Member's Terminal Illness. CalOptima Health shall review and make medical determination for requests for Special Physician Services for pain and symptom management based on medical justification. The Special Physician Services shall not be provided by the Member's Hospice attending physician and requires:

    a. Immediate need; and

    b. The Hospice attending physician does not have the required special skills.

2. Special Physician Services is limited to one (1) visit-per-day, per Member.

L. CalOptima Health and its Health Networks, in accordance with the Health Network-specific DOFR, are responsible for the provision of all Medically Necessary Covered Services not related to a Member's Terminal Illness, including covered services provided by a Member's Primary Care Provider (PCP).

M. CalOptima Health or its Health Network, in accordance with the active DOFR, may provide ongoing care coordination to a OneCare, or Medi-Cal primary Member receiving Hospice Care to ensure that services necessary to diagnose, treat, and follow-up on conditions not related to the Terminal Illness continue to be provided, or are initiated, as necessary.

N. The Member may still receive medical services not related to the Terminal Illness through Medicare Part A and B or a Medicare health plan.

O. CalOptima Health shall not approve any claims requests submitted after one (1) year from the date of service.

P. For exceptional circumstances, Hospice Providers that submit a claim after twelve (12) months from the month of service shall provide acceptable documentation justifying the reason for delay. Acceptable documentation may include:

1. Court decisions;

2. Fair hearing decisions;

3. County administrative errors in determining Member eligibility;

4. Reversal of decisions on appealed Authorization Request Form (ARF);

5. Medicare/Other Health coverage delays; or

6. Other circumstances beyond the Hospice Provider's control (i.e., natural disasters).

Q. CalOptima Health shall ensure for any authorizations for which it is responsible, for Hospice Care services under the Medi-Cal benefit, are consistently applied to medical/surgical, mental health, and substance use disorder services.

III. PROCEDURE

A. CalOptima Health or its Health Networks, in accordance with the Health Network-specific DOFR, shall be responsible for providing Hospice Care to a Medi-Cal primary Member if the following criteria are validated:

1. The physician has executed a certification of Terminal Illness that complies with Title 42 Code of Federal Regulations (CFR), Section 418.22.

2. The Notice of Election or Revocation Statement is signed by the Member or Member's Authorized Representative. The following must be included on the form:

   a. Identification of the Hospice Provider;

   b. The Member's or the Member's Authorized Representative's acknowledgement that he or she has full understanding that the Hospice Care services given as related to the Member's Terminal Illness will be palliative, rather than curative in nature, unless the Member is a child under twenty-one (21) years of age, and that certain specified Medi-Cal benefits are waived by the election;

   c. The effective date of election; and

   d. The signature of the Member or the Member's Authorized Representative.

B. A Hospice Provider shall be responsible for services related to the Member's Terminal Illness, including, but not limited to, pharmacy, physician, social services, nursing, home health aide services, home maker services, Durable Medical Equipment (DME), supplies, multi-disciplinary hospice services, hospice physician consultation for patients, dietary or nutritional counseling, bereavement, and grief and spiritual counseling.

C. For a Member residing in an LTC facility, reimbursement will follow the Level of Care table below:

Level of Care	**Service Location**	**Payment**
Routine Home Care	Private home, residential care facility, board and care or nursing facility A or B level.	Standard hospice per diem for Routine Home Care
Continuous Home Care	Private home, residential care facility, board and care or nursing facility A or B level.	Standard hospice per diem for Continuous Home Care
Respite Care	Skilled nursing facility or acute facility.	Standard hospice per diem for Respite Care
General Inpatient Care	Skilled nursing or acute facility.	Standard hospice per diem for General Inpatient Care

D. For Medi-Cal primary Members, CalOptima Health may approve General Inpatient Care on a short-term basis for pain control or management of acute and severe problems. A Hospice Provider must submit the following documents:

1. CalOptima Health Hospice Notification/Validation Form (HNVF);

2. Physician orders for General Inpatient Care signed by the Member's attending hospice physician;

3. Member's Hospice Election Form;

4. Initial written Plan of Care;

5. Certification of Terminal Illness by a physician;

6. Clinical documentation that indicates Medical Necessity for General Inpatient Care; and

7. Medication Administration Records or Flow Charts that document services medically required for the General Inpatient Care.

E. Medi-Cal primary Members may be admitted for General Inpatient Care for any one (1) or more of the reasons specified below:

1. Pain control

    a. Required frequent evaluation by a physician/registered nurse;

    b. Need more aggressive treatment to control pain than can be attained in a home setting; or

    c. Frequent adjustment of medications.

2. Management of symptoms such as:

    a. Sudden acute general deterioration requiring intensive nursing intervention;

    b. Protracted nausea and vomiting;

    c. Respiratory distress which becomes unmanageable, requiring administration of continuous oxygen;

    d. Major pathological fracture;

    e. Open lesions not responsive to home care and in need of frequent skilled care;

    f. Rapid decline or debilitating cachexia inconsistent with home care management; and

    g. Psychological and social problems such as, but not limited to:

        i. Acute anxiety or depression not responding to milieu therapy;

ii. Collapse of family support resulting from the disease process which requires intensive skilled care in other than the home environment; and

iii. Psychosis or severe confusion secondary to the underlying organic disease.

F. Hospice Notification and Validation for CalOptima Health Medi-Cal primary Members

1. A Hospice Provider shall submit Notification of Hospice election immediately and no later than thirty (30) calendar days after start of services. In cases of Medi-Cal retroactive eligibility, the Notification must be submitted within one hundred twenty (120) calendar days after the State of California's eligibility determination.

2. Notification/Validation requests submitted after thirty (30) calendar days after start of services, or the one hundred twenty (120) calendar days requirement shall not be approved for those services rendered before the submission of a completed Notification/Validation request.

3. If medical justification is not included or is inadequate for Continuous Home Care or General Inpatient Care, a CalOptima Health Medical Director may modify the request to a lower Level of Care pursuant to CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. A Hospice Provider shall have the right to appeal the Level of Care decision, in accordance with CalOptima Health Policies GG.1510: Appeal Process and MA.9003: Standard Pre-Service Appeal, MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9015: Standard Integrated Appeals.

4. The Hospice Provider shall submit Notification of continued service to CalOptima Health, or its Health Network using the Hospice Notification/Validation Form (HNVF) prior to the expiration of the current election period and shall include:

a. Recertification of Terminal Illness: For the third benefit period re-certification, and every re-certification thereafter, there must be a face-to-face encounter between the Member and the certifying provider no more than thirty (30) days prior to the certification date, to gather clinical findings to determine continued eligibility for hospice care.

5. Attestation requirements:

a. Face-to-face encounter with Member is required to determine eligibility and must be performed by hospice physician or hospice nurse practitioner employed by the Hospice Provider;

b. Physician signature and date must be separate and a distinct section of, or an addendum to, the recertification form and must be clearly titled.

c. Attestation performed by a nurse practitioner:

i. Must state clinical findings of visit was provided to the certifying physician; and

ii. Determine life expectancy of six (6) months or less, should the illness run its normal course.

6. Timeframe requirements when a Member transfers from one Hospice Provider to another Hospice Provider:

a. A receiving Hospice Provider may not know if a face-to-face recertification is necessary, as such, the receiving Hospice Provider shall document in the Member's medical record all efforts to obtain the previous hospice benefit period Certification of Terminal Illness, either from the transferring Hospice Provider or from other sources; and

b. If the receiving Hospice Provider cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving Hospice Provider completes the intake process. This information must be maintained in the Member's medical record for auditing purposes.

7. Timeframe for exceptional circumstance:

   a. Face-to-face encounter is not obtained due to the Member is in the third or later benefit period; or

   b. Emergency weekend admission; or

   c. Centers for Medicare & Medicaid Services (CMS) Data System and/or Provider Electronic Health Record are not available; the Hospice Provider may be unaware that the Member is in the third or later benefit period. In such documented cases, a face-to-face encounter that occurs within two (2) calendar days after admission will be considered timely; or

   d. Member expires within two (2) calendar days of admission without a face-to-face encounter.

8. Medically Necessary Covered Services for conditions not related to a Member's Terminal Illness that are provided to a Member receiving Hospice Care services shall require the same prior authorizations as required for a Member not receiving Hospice Care services.

9. For all CalOptima Health Members in an LTC facility electing Hospice Care services, the Hospice Provider shall submit a completed Hospice Notification/Validation Form (HNVF) and the following documents to CalOptima Health's LTSS Department:

   a. Initial Plan of Care, including a physician signature and date;

   b. Certification of Terminal Illness, including a physician signature and date; and

   c. Hospice Election Form, including the election date and signature of the Member or the Member's Authorized Representative.

10. Pharmacy

    a. Medications related to the Member's Terminal Illness including, but not limited to: hydration, pain, and nausea control, whether administered orally, by injection or intravenous (IV), shall be included in the per diem hospice rate. These medications shall be obtained through the hospice program and not the CalOptima Health pharmacy system.

    b. Medications required for medical conditions not related to Member's Terminal Illness, such as insulin for a diabetic, shall continue to be covered under the CalOptima Health pharmacy program and shall be processed through the CalOptima Health pharmacy system, or by the Health Network for those drugs covered under the Health Network's responsibility.

IV. ATTACHMENT(S)

A. Notice of Election or Revocation Statement
B. Hospice Notification/Validation Form (HNVF)

V. REFERENCE(S)

A. California Children's Services (CCS) Numbered Letter 06-1011: Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care
B. California Children's Services (CCS) Numbered Letter 12-1119: Palliative Care Options for CCS Eligible Children - Revised
C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
E. CalOptima Health Policy GG.1510: Member Appeal Process
F. CalOptima Health Policy GG.1550: Palliative Care Services
G. CalOptima Health Policy GG.1814: Appeals Process for Long Term Care Facility
H. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
I. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
J. CalOptima Health Policy MA.9015: Standard Integrated Appeals
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 13-014: Hospice Services and Medi-Cal Managed Care
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020: Palliative Care (Supersedes APL 17-015)
M. Department of Health Care Services (DHCS) Hospice Care: General Billing Instructions
N. Department of Health Care Services (DHCS) Policy Letter (PL) 11-004: The Implementation of Section 2302 of The Affordable Care Act, Entitled "Concurrent Care For Children"
O. Health and Safety Code, §§1339.31(b) and 1368.2
P. Hospice Financial Responsibility Matrix
Q. Manual of Criteria (MOC) for Medi-Cal Authorization
R. Medicare Claims Processing Manual, CR 9201, Chapter 11, Section 30.2.2
S. Social Security Act, Sections 1905(o)(1), 1812(d)(1) and 2110(a)(23)
T. Title 22, California Code of Regulations, §§51349 and 51180 et seq.
U. Title 42, Code of Federal Regulations, §418 et seq.
V. Welfare and Institutions Code, §14133.85

VI. REGULATORY AGENCY APPROVAL(s)

Date	Regulatory Agency	Response
03/01/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/21/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
08/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2001	GG.1503	CalOptima Authorization Requirements for the Provision of Hospice Service	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2007	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	10/01/2009	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	07/01/2013	GG.1503	CalOptima Coverage, Notification and Validation Requirements	Medi-Cal
Revised	03/01/2014	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal
Revised	05/01/2016	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	08/06/2020	GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	06/01/2021	GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	07/01/2023	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	09/01/2024	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorized 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: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
California Children's Services (CCS) Eligible Conditions	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
CalOptima Health Direct Administrative (COHD-A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members as described in CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Continuous Home Care	Hospice care provided in the Member's residence, which consists predominately of skilled nursing care, for a minimum of eight (8) hours in a 24-hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the Member's care.
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:

Term	Definition
	1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 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

Term	Definition
	51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Crisis	The period in which a Member requires continuous care for as much as twenty-four (24)-hours to achieve palliation or management of acute medical symptoms.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
General Inpatient Care	Services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management.
Health Network	For purposes of this policy, a Physician-Hospital Consortia (PHC), or a Shared Risk 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.
Hospice Care	The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition,

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	by a Hospice Provider or by others under arrangements made by a Hospice Provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home; 11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility. 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.
Hospice Intensity Service (Add-On)	For purposes of this policy, Hospice services for routine home hospice level of care that can be billed during the last seven (7) days of life in fifteen (15) minute increments and not to exceed four (4) hours per day for a maximum of seven (7) days. 1. Code G0155: Services of clinical social worker in home health or hospice setting each fifteen (15) minutes. 2. Code G0299: Direct skill nursing services of a registered nurse (RN) in the home health or hospice setting, each fifteen (15) minutes. 3. Codes do not require prior authorization with a maximum of one hundred twelve (112) units allowed for the last seven (7) days of Member's life.
Hospice Provider	A public agency or private organization, or a subdivision thereof, or a facility which: 1. Is primarily engaged in providing the items and services described in Title 22, California Code of Regulations, Section 51180 to Terminally Ill Members; 2. Makes such services available as needed on a 24-hour basis, and 3. Provides bereavement counseling for the immediate family and significant others.
Level of Care (LOC)	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health policies.

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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 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 1396d(r)(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. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	Medi-Cal: 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. OneCare: A beneficiary enrolled in a CalOptima Health OneCare program.
Notification	For purposes of this policy, direct communication to LTSS staff for hospice services notification for routine home care, continuous and Respite Care within thirty (30) calendar days of start of services for CalOptima Health Members.
Physician Services	For purposes of this policy, general supervisory services of the hospice medical director; participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician of the hospice interdisciplinary team.
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Respite Care	Hospice care provided short-term inpatient care in an acute hospital, skilled nursing facility/Level B, intermediate care facility/Level A, or a hospice facility which is organized to provide inpatient care directly, when necessary to relieve family Members or others primarily caring for the Member.
Routine Home Care	Hospice care provided in the Member's residence which is not Continuous Home Care.

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Special Physician Services	For purposes of this policy, services to manage symptoms that cannot be remedied by the Member's Hospice attending physician because of one of the following: 1. Immediate need; and 2. Hospice attending physician does not have the required special skills. Code 0657 should be billed on a separate line for each date of service and is limited to once per day, per Member, per hospice provider.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Terminally Ill	A medical prognosis certified by a physician is that a Member's life expectancy is six (6) months or less if the terminal illness runs its normal course.
Validation	For purposes of this policy, documentation to support medical justification for services requested for CalOptima Health Members.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.