Policy:	GG.1508
Title:	**Authorization and Processing of Referrals**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 11/22/2024*
Effective Date:	01/01/1996
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Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the procedure by which CalOptima Health and its Health Networks shall process a request for Prior Authorization, Concurrent Review, and Retrospective Review of Covered Services for a Member.

II. POLICY

A. CalOptima Health and its Health Networks shall process requests for Prior Authorization, Concurrent Review, and Retrospective Review within the timeframes specified in this Policy. CalOptima Health and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

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. For Members enrolled in OneCare, CalOptima Health or a Health Network, as applicable, shall accept an Organization Determination request from a Member or Member's Authorized Representative and shall not redirect the Member or Member's Authorized Representative to the Provider office to make such request.

1. If a OneCare Health Network Member calls CalOptima Health before contacting the Health Network regarding an authorization, CalOptima Health shall transfer such calls to the appropriate Health Network Customer Service line for assistance.

D. CalOptima Health and its Health Networks shall follow the applicable Timeframes for Decisions and Notifications Table, as set forth in Attachments A and B of this Policy, for all requested

services, whether in- or out-of-network, as well as CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. CalOptima Health and its Health Networks shall ensure that clinical decision made related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, and GG.1541: Utilization Management Delegation.

F. With respect to the Whole Child Model (WCM) program, CalOptima Health and its Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as California Department of Health Care Services (DHCS) guidance, including, but not limited to, All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima Health and the Health Networks shall:

    1. Use all current and applicable California Children's Services (CCS) Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS Numbered Letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

    2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.

G. CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

H. CalOptima Health and its Health Networks must notify network providers of all services that require prior authorization, concurrent authorization or retrospective authorization.

I. CalOptima Health and the Health Networks shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage. CalOptima Health and the Health Networks do not reward Practitioners or other individuals for issuing denial for coverage, care, or services. CalOptima Health and the Health Networks do not provide financial incentives to utilization management decision-makers to encourage decisions that result in underutilization.

J. CalOptima Health and the Health Networks shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in Section III.A. of this Policy.

K. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

    1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network and in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services.

    2. For Health Network Members, a Provider, including a Specialist Physician, shall follow the Health Network's authorization process.

L. A Provider or Practitioner may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider or Practitioner's ability to obtain a Prior Authorization request and when one (1) of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or

2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable and CalOptima Health eligibility at the time of service.

3. Retrospective submission timeframe:

   a. For a OneCare Member as long as such request is made within sixty (60) calendar days after the initial date of service.

   b. For a Medi-Cal Member as long as such request is made within a reasonable established time limit, not to exceed three-hundred sixty-five (365) calendar days from the date of service.

M. CalOptima Health and a Health Network shall ensure that all contracted Providers and non-contracting Specialist Physicians and Providers are informed of the Prior Authorization and Referral process at the time of Referral.

N. CalOptima Health and its Health Networks that are responsible for utilization management of hospital services shall have a plan health professional or a contracting, qualified, and licensed physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization Care Services, to coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

O. CalOptima Health and its Health Networks shall provide coverage and payment, for hospital Emergency Services and Post Stabilization Care Services necessary to determine the presence or absence of an Emergency Medical Condition, and if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member's condition regardless of whether or not the request is from a contracted Provider, Non-Contracted Provider or Out-of- Network, as specified in Section III.D, E, and G of this Policy.

P. If a Member exhausts his or her Medicare benefits as provided under the OneCare Program, and at the request of the Health Network under a shared risk contract, CalOptima Health shall authorize Covered Services in accordance with this Policy or other applicable CalOptima Health policies and procedures.

Q. CalOptima Health and its Health Networks shall maintain a system for tracking and monitoring all Referrals for Provider and Member-requested (OneCare Members only) health care services and supplies requiring Prior Authorization as follows:

1. Referral turnaround time for issuing a determination;

2. Criteria used in making the determination;

3. If denied, deferred, or modified, a copy of the Notice of Action (NOA); and

4. Specific services and supplies approved, denied, deferred, or modified, including classifying non-medical necessity denials.

III. PROCEDURE

A. Services Excluded from the Prior Authorization Process

1. For the Medi-Cal, and OneCare programs, the following services do not require Prior Authorization:

   a. Emergency Services or emergency care

      i. CalOptima Health and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

      ii. CalOptima Health and its Health Networks shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

      iii. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on such Member's assigned Health Network or on CalOptima Health if such Member is a CalOptima Health Direct Member, whichever is applicable.

   b. Preventive and primary care services, including recommended routine immunizations;

   c. Basic prenatal care;

   d. Family Planning Services:

      i. Health education and counseling necessary to make informed choices and to understand contraceptive methods;

      ii. Limited history and physical examination for family planning services;

      iii. Laboratory tests, if medically indicated, as part of the decision-making process for selecting a method of contraception;

      iv. Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated, during one (1) visit;

      v. Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and Referral for treatment;

      vi. Provision of contraceptive pills, devices, and supplies;

      vii. Follow-up care for complications associated with contraceptive methods issued by a family planning Provider or Practitioner;

      viii. Tubal ligation;

      ix. Vasectomies; and

      x. Pregnancy testing and counseling.

e. Routine obstetrical services; and

f. Elective abortions. *Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization.

i. CalOptima Health shall cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion.

ii. CalOptima Health shall not impose annual or lifetime limits on the coverage of outpatient abortion services.

g. Cancer Biomarker testing services for a Member who meets the following criteria, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing:

i. Advanced or metastatic stage three (3) or four (4) cancer; or

ii. Cancer progression or recurrence in the Member with advanced or metastatic stage 3 or 4 cancer.

iii. For the CalOptima Health Direct and CalOptima Health Community Network programs, a Provider or Practitioner shall submit:

a) For portal authorizations, when biomarker testing is requested, the Provider will attest to the Member having stage three (3) or stage four (4) cancer and the request will be processed.

b) For fax authorizations where biomarker testing is requested, the Provider will attest to the stage 3 and 4 cancer diagnosis on the Authorization Request Form (ARF).

2. For the OneCare program, in addition to the services identified in Section III.A.1. of this Policy, the following services do not require Prior Authorization:

a. Services for Emergency Medical Conditions, including emergency Behavioral Health Care;

b. Urgent Care sought outside of the service area of Orange County, California;

c. Urgent Care under unusual and extraordinary circumstances provided in the service area of Orange County, California when the contracted medical provider is unavailable or inaccessible; and

d. Out-of-area renal dialysis services.

3. For the Medi-Cal Program, in addition to the services identified in Section III.A.1. of this policy, the following services do not require Prior Authorization:

a. Minor Consent Services: The following Minor Consent Services provided to a CalOptima Health Medi-Cal Member less than twenty-one (21) years of age do not require parental consent or Prior Authorization. Minor Consent Services are Covered Services of a sensitive nature related to:

i. Sexual assault, including rape;

ii. Drug or alcohol abuse for a Member twelve (12) years of age or older;

iii. Pregnancy;

iv. Family Planning, including termination of pregnancy *Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization;

v. Sexually transmitted diseases (STDs) or HIV/AIDS for a Member twelve (12) years of age or older; and

vi. Non-Specialty Mental Health Services (NSMHS) for children ages twelve (12) and over who are mature enough to participate intelligently in their health car pursuant to Family Code Section 6924.

b. Initial mental health assessments; and

c. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.

B. Responsibilities of Primary Care Provider (PCP) and Specialist Physician

1. A PCP is required to maintain twenty-four (24) hour access for the Member, including availability for response to emergency and urgent questions from the Member in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities. When possible, the PCP shall evaluate and counsel the Member, and direct the Member to the most appropriate level of service based on the Member's condition.

2. All services shall be provided in the manner and time frames set forth in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

3. Member Eligibility Verification

a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima Health identification card, or shall perform an eligibility verification using CalOptima Health's Provider Portal at www.caloptima.org.

b. Prior Authorization does not guarantee eligibility at the time services are rendered.

c. For Medi-Cal Members, a Provider or Practitioner shall verify eligibility at the time the services are provided, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

C. Authorization Requests

1. For a CalOptima Health Direct Member, a Practitioner or Provider shall request the following authorizations in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations described in Section II.L. of this Policy.

2. For a Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with the Health Network's authorization policy:

   a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

   b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

   c. Request for Retrospective Review subject to the limitations described in Section II.L. of this policy.

3. An Urgent Authorization Request may be submitted if a routine authorization timeframe will be detrimental to a Member's life or health, jeopardize the Member's ability to regain maximum function, or may result in loss of life, limb, or other major body function. Such request is required to be decided within seventy-two (72) hours or as soon as the Member's health condition requires.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health or a Health Network, as applicable, prior to a Member's admission to inpatient status.

5. All CalOptima Health and Health Network authorization requests must include clinical records that validate the need for the requested item or service.

D. Hospital Notification of Emergency Services

1. A hospital shall notify CalOptima Health or the Member's Health Network, as applicable, within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification system is implemented, a hospital shall use best efforts to provide such notice within twenty-four (24) hours of the Member's presentation to the emergency department for outpatient Emergency Services.

2. If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima Health or the Member's Health Network shall be made the following business day, or the time Member identity is known, or would have been known with the exercise of reasonable diligence.

E. Prior Authorization Request (Post-Stabilization Care Services)

1. Medically Necessary Post-Stabilization Care Services from Contracted Providers and Non-Contracted Providers

   a. A hospital must submit a Prior Authorization request for Post-Stabilization Care Services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

      i. Related to the Emergency Medical Condition; and

      ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.

b. All requests and responses to a Post Stabilization Care Service request are required to be fully documented. Documentation shall include but is not limited to;

   i. The date and time of the request;

   ii. The name of the health care Provider making the request; and

   iii. The name of the CalOptima Health or Health Network staff responding to the request.

c. A Prior Authorization request for Medically Necessary Post-Stabilization Care Services shall consist of a completed and signed authorization request form from the facility to CalOptima Health or a Health Network's Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare:

   i. Identifying information including Member name, birthdate, CIN, and gender;

   ii. Name and role of facility clinician requesting prior authorization, their direct phone number and the name of facility;

   iii. Nature of the emergency condition that has been stabilized;

   iv. Medical documentation to include at a minimum:

      a) History and physical;

      b) Vital signs; and

      c) Laboratory and/or radiology results.

   v. Co-morbid conditions; and

   vi. Medical reason for admission to the hospital including proposed treatment.

d. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request for Medically Necessary Post-Stabilization Care Services in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

e. For a Health Network Member enrolled in the Medi-Cal program, the Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within thirty (30) minutes after receipt of request that fully complies with Section III.E.1.a-c of this Policy. If the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care Services are deemed approved.

   i Notwithstanding Section III.E.1.d. of this Policy, pursuant to Section 1300.71.4 of Title 28 of the California Code of Regulations, the Health Network may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of Post-Stabilization Care Services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.

ii In the case where the Health Network denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

f. For a Health Network Member enrolled in the OneCare program, a Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within sixty (60) minutes after receipt of request that fully complies with Section III.E.1a-c of this Policy. If the Health Network does not respond to such request within sixty (60) minutes, Medically Necessary Post-Stabilization Care Services are considered approved.

g. CalOptima Health and its Health Networks are also financially responsible for Post-Stabilization Care Services in the event that CalOptima Health or the Health Network:

i. Did not respond to a request for pre-approval within the timeframe allotted (Medi-Cal within thirty (30) minutes, OneCare within sixty (60) minutes);

ii. Could not be contacted; or

iii. Could not reach an agreement with the treating Provider concerning the Member's care and CalOptima Health or the Health Network physician was not available for consultation.

h. In the case where CalOptima Health or a Health Network and the treating Provider cannot reach an agreement concerning the Member's care and the CalOptima Health or Health Network physician is not available for consultation, CalOptima Health or the Health Network shall give the treating Provider the opportunity to consult with a CalOptima Health or Health Network physician and the treating Provider may continue with care of the Member until a CalOptima Health or the Health Network physician is reached or one (1) of the following criteria is met:

i. CalOptima or the Health Network physician with privileges at the treating Provider's hospital assumes responsibility for the Member's care;

ii. CalOptima Health or the Health Network physician assumes responsibility for the Member's care through transfer;

iii. CalOptima Health or the Health Network and the treating Provider reach an agreement concerning the Member's care; or

iv. The Member is discharged.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary non-urgent care following an exam in the emergency room in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

b. For a Health Network Member enrolled in the Medi-Cal program, a Health Network shall approve or deny a Prior Authorization request for non-urgent care following an exam in the emergency room within thirty (30) minutes after receipt of such request from a non-

contracted Provider on behalf of a Member, who has received Emergency Services. If the Health Network does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. Health Network staff shall assist the hospital with timely Discharge Planning to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

F. Second Medical Opinions

1. A Member or the Member's Authorized Representative has the right to request a second opinion.

2. For Medi-Cal, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's Customer Service Department (714-246-8500 or toll-free at 888-587-8088/TDD/TTY: 711), or the Member's Health Network.

3. For OneCare, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's OneCare Customer Service Department (714-246-8711 or toll-free at 877-412-2734/TDD/TTY: 711), or the Member's Health Network.

4. CalOptima Health or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.

5. A Member may receive a second opinion from an in-network Provider at no cost. If an in-network Provider is not available, CalOptima Health or their Health Network shall make arrangements for the Member to obtain a second opinion from an out-of-network Provider at no cost.

6. A Member may receive a third opinion, at no cost to a Member, if there is a disparity between the initial and second opinion.

G. Out-of-Network Services

1. CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

2. CalOptima Health or a Health Network shall adequately and timely cover out-of-network services, for as long as CalOptima Health or the Health Network is unable to provide the services within the network. CalOptima Health or the Health Network shall process out-of-network service requests, as specified in the Timeframes for Decisions and Notifications Tables.

3. All requests requiring Prior Authorization shall require the requestor to submit a fully completed Authorization Request Form to CalOptima Health along with medical justification sufficient to make a determination and the physician signature. CalOptima Health shall process the request, as specified in the Timeframes for Decisions and Notifications Tables.

4. CalOptima Health or a Health Network shall follow the Timeframes for Decisions and Notifications Tables for all requested services, whether in or out of the network.

5. CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

6. CalOptima Health or a Health Network shall provide continued access as follows:

    a. For newly enrolled Medi-Cal beneficiaries, for up to twelve (12) months, to an out-of-network Provider with whom the Member has had an ongoing relationship if there are no quality-of-care issues with the Provider and the Provider accepts contracted or Medi-Cal rates in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

    b. For Members eligible with the California Children's Services (CCS) Program and transitioned into the WCM program, for up to twelve (12) months, to an out-of-network CCS-paneled Provider, specialized or customized durable medical equipment provider, currently prescribed medication, and public health nurse, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services, and GG.1330: Case Management – California Children's Services Program/Whole Child Model.

H. Denials, Deferrals, Dismissals, Terminations and Modifications of Prior Authorization Requests

1. In-Network Specialist Physician. CalOptima Health or a Health Network may redirect specialty care Prior Authorization requests to an in-network Specialist Physician under the following conditions:

    a. All modification, denial, dismissal, termination and notification requirements are followed pursuant to regulation requirements; and

    b. The in-network Specialist Physician is selected based on the following:

        i. A demonstrated ability to provide the services requested;

        ii. Prolific experience providing the services requested;

        iii. Volume of the requested care previously provided;

        iv. An existing relationship with CalOptima Health or the Health Network, as applicable;

        v. A proven ability to maintain adequate Member access;

        vi. A proven ability to provide care coordination;

        vii. No existing issues related to continuity of care or Tertiary service needs; and

        viii. For Members eligible with the CCS Program and transitioned into the WCM program, a CCS-paneled provider qualified to treat the CCS-Eligible Condition of the CCS child or youth, in accordance with CCS Program rules and regulations.

2. Consultation with Board-Certified Specialist.

    a. CalOptima Health may consult with a Board-Certified specialist if the Prior Authorization request is out of the scope of practice of the physician reviewer.

i. A CalOptima Health Medical Director shall forward a request for review by a Board-Certified specialist to the Prior Authorization manager or Designee for appropriateness;

ii. The Prior Authorization manager or Designee shall forward the request to a contracted external review agency electronically for review; and

iii. Upon receipt of the recommendation of the external review agency, the CalOptima Health Medical Director shall conduct the final review and determination.

b. The UMC shall maintain a list of Board-Certified specialists and will be reviewed annually by the Quality Improvement Committee (QIC).

3. Tertiary Care

a. CalOptima Health or a Health Network shall authorize Tertiary Care Services when a Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care.

b. CalOptima Health shall only authorize Tertiary Care services under the following circumstances:

i. A Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care;

ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated plan of care;

iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-Tertiary level of care;

iv. A Member or Provider requires a referral for experimental or investigational procedures not available in-network and may do so directly through CalOptima Health; and

v. There is no quality-of-care issues for the Provider.

4. Utilization Management (UM) Decision. CalOptima Health and its Health Networks shall ensure the following:

a. Requested health care services may be approved by UM staff who are not qualified health care professionals only when:

i. The UM staff is under the supervision of an appropriately licensed health professional;

ii. There are explicit UM criteria; and

iii. No clinical judgement is required.

b. Requested health care services which require the use of clinical judgement shall be approved by licensed health care professionals.

c. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified medical director with a current and unrestricted license to practice in California or other health care professional with

appropriate clinical expertise in treating the condition and disease, including knowledge of Medicare and Medi-Cal coverage criteria.

i. Only a qualified, licensed physician or other qualified health care professional, as appropriate, shall deny or authorize an amount, duration, or scope less than the requested health care services based in whole or in part on Medical Necessity for any non-behavioral healthcare services.

ii. Only a qualified, licensed physician or appropriate behavioral healthcare practitioner as appropriate shall review and issue denials for Behavioral Health Care services for Medical Necessity or benefit coverage related to a Medi-Cal Member's behavioral health benefits; and

iii. Only a qualified, licensed physician or qualified, licensed clinical pharmacist shall review and approve, defer, modify or deny prior authorizations for pharmaceutical services.

d. Only qualified, licensed health care professionals supervise review decisions requiring Prior Authorization, including service reductions, and a qualified, licensed physician shall review all denials of a request for health care services based in whole or in part on Medical Necessity.

5. Notification of UM Decision

a. CalOptima Health and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. In addition, for OneCare, CalOptima Health and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Health Policy MA.6042: Integrated Organization Determinations.

b. If Medical Necessity criteria are not met, and review by a CalOptima Health or Health Network qualified licensed physician does not find the Member requires the requested inpatient level of care and Prior Authorization request is denied, delayed, modified, or alternative treatment is recommended, CalOptima Health or a Health Network shall notify the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action.

i. 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.

ii. Communication needs of 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 PolicyDD.2002: Cultural and Linguistic Services.

c. For routine (non-urgent) authorization requests, if CalOptima Health or a Health Network does not take action by approving, denying, deferring, or modifying services, on a written

request for Prior Authorization of Covered Services within fourteen (14) calendar days after receipt, such request shall be deemed denied by default and a notification of denial for the requested service shall be sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. Availability of CalOptima Health UM Staff and Services

1. CalOptima Health's UM Department shall provide Members or potential Members access to information, about the UM process, and the process for authorizing care, in the Medi-Cal Member Handbook, and OneCare Evidence of Coverage available in-print and on the CalOptima Health website at www.caloptima.org.

2. CalOptima Health's UM Department shall provide Practitioners access to information about the UM process, and the process for authorizing care, in the Provider Manual, available on the CalOptima Health website at www.caloptima.org.

3. UM staff shall be available for inbound calls including toll free and collect calls, regarding UM issues during CalOptima Health normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima Health's Customer Service Department and routed to appropriate UM staff.

   a. UM staff shall provide a toll-free number (and accept collect calls regarding UM issues.

   b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

   c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.

   d. UM staff shall be accessible to callers who have questions about the UM process.

   e. UM qualified, licensed physicians shall be available to answer denial determination questions during normal business hours and after hours calls regarding UM issues. During business hours, calls shall be directed to the UM Department and transferred to the appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.

   f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.

4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). Communications received after normal business hours are returned on the next business day. Communications received after midnight on Monday-Friday are responded to on the same business day.

5. CalOptima Health shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic and Services (CalOptima Health is able to receive and send TDD/TYY messages and has a separate phone number for receiving TDD/TYY messages.).

6. CalOptima Health shall provide language assistance services free of charge to Members. CalOptima Health shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

7. CalOptima Health shall send a CalOptima Health Medi-Cal Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Health Policy DD.2005: Member-Informing Materials Requirements. The handbook will note availability of UM staff in regard to UM issues and will include the Customer Service Department phone number and the TDD/TTY phone number.

8. Annually, CalOptima Health shall inform Medi-Cal Members of the availability of the CalOptima Health Member Handbook/Evidence of Coverage.

9. Annually, CalOptima Health shall send via U.S. Mail the OneCare Evidence of Coverage, for OneCare Members.

J. Failure of a Health Network or CalOptima Health department to comply with CalOptima Health's authorization policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action which may include, but not be limited to, education and training on CalOptima Health's authorization process and reports to the Utilization Management Committee (UMC), Delegation Oversight Committee (DOC), and/or the Compliance Committee.

1. Continued non-compliance may lead to issuance of a Corrective Action Plan (CAP) and/or Sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

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

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Dual Eligible Special Needs Plans (D-SNPs)
C. Medicare Managed Care Manual "Benefits and Beneficiary Protections", Section 20.3 Section 20.4 and Section 20.5.2
D. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health, Health Network Service Agreement
G. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
H. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
I. CalOptima Health Policy DD.2005: Member-Informing Materials Requirements
J. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
K. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
L. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
M. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities

N. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
O. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
P. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
Q. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
R. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
S. CalOptima Health Policy HH.2002: Sanctions
T. CalOptima Health Policy HH.2005: Corrective Action Plan
U. CalOptima Health Utilization Management Program
V. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Revised 08/31/2022)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection for Members with Visual Impairments
X. Department of Health Care Services All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
Y. Department of Health Care Services (DHCS) All- Plan Letter (APL) 22-010: Cancer Biomarker Testing
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services
AA. Department of Health Care Services All Plan Letter (APL) 23-034: California Children's Services Whole Child Model Program (Supersedes APL 21-005)
BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services (Supersedes APL 22-022)
CC. California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)
DD. Health and Safety Code, Sections 1363.5 and 1367.01
EE. Family Code, Section 6924
FF. Medi-Cal Member Handbook
GG. OneCare Evidence of Coverage
HH. Title 28, California Code of Regulations (CCR), §1300.71.4
II. Title 42, Code of Federal Regulations (CFR), §§ 422.113 (b)(2)(ii), (b)(3) and (c), 422.138(a) and (b)(1-3), 422.562 (a)(4), 422.566 (a)(d), 422.590 (h), 422.629 (k)(3) and (4), 423.562(a)(5), 423.566 (a)(d), 423.590 (f), 438.114 (a), 438.404(a) and (c)(5), and 438.910(d)
JJ. National Committee for Quality Assurance (NCQA) HP Standards and Guidelines, MED 9 Element D, Factor 3

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/02/2009	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/17/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2018	Department of Health Care Services (DHCS)	Approved as Submitted
04/19/2021	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
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

Date	Regulatory Agency	Response
02/22/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/19/2023	Department of Health Care Services (DHCS)	File and Use
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/1998	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	05/01/1999	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	07/01/2000	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	10/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	06/01/2007	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2011	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	02/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	11/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2013	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2014	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Correction	05/10/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	03/01/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/03/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	09/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	01/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	08/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	12/31/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	02/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	11/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorized Representative	For purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services
Autism Spectrum Disorder (ASD)	A developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Health Direct	A direct health care program operated by 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.

Term	Definition
Comprehensive Diagnostic Evaluation	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an Out-of-Network Provider with whom the Member has a pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; and 5. Appropriate discharge planning; and Timely placement at different levels of care including hospital, skilled nursing, and home health 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: 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

Term	Definition
	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; 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. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

Term	Definition
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	Medi-Cal: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; and/or 3. Serious dysfunction of any bodily organ or part. OneCare: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Medi-Cal: Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), 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.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first.

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.
Member	A beneficiary enrolled in a CalOptima Health program.
Non-Contracted Provider	Medi-Cal: A Provider that is not obligated by written contract to provide Covered Services to a Member. OneCare: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Non-Specialty Mental Health Services (NSMHS)	Mild-to-moderate mental health coverage requirements of CalOptima for Medi-Cal Members that are delivered via managed care and include the following: 1. Mental health evaluation and treatment, including individual, group and family psychotherapy 2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition 3. Outpatient services for purposes of monitoring drug therapy 4. Psychiatric consultation 5. Outpatient laboratory, drugs, supplies and supplements
Organization Determination	Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.
Out-of-Area	Outside of the Service Area

Term	Definition
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the Service Area Provider [CalOptima Health]: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care Services	Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 31 438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition.
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), or Speech and Language Therapist, furnishing Covered Services.
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.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Qualified Licensed Physician	For purposes of this policy, if CalOptima Health or a Health Network expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the request shall be reviewed by a qualified licensed physician with a current and unrestricted license to practice in California or other appropriate health professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medi-Cal coverage criteria, before issuing the Coverage Decision Letter (OD) or Notice of Action (NOA).

Term	Definition
Referral	The process of a Provider directing a Member to another Provider for care and /or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Tertiary Care	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.
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), 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.