Policy:	GG.1113
Title:	**Specialty Practitioner Responsibilities**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	02/01/1998
Revised Date:	12/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the responsibilities of a Specialty Practitioner for CalOptima Health Members.

II. POLICY

A. A PCP shall retain responsibility for a Member referred to a Specialty Practitioner in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role and Responsibilities.

B. If a Member requires specialty care, a Provider shall request authorization for a Specialty Practitioner consultation or care for a specified period of time with 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.

C. For specialty care needed by a Member under twenty-one (21) years of age that may be due to a CCS-Eligible Condition, the Provider shall refer to a CCS-paneled Practitioner.

D. For services that do not require Prior Authorization, Providers 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.

2. For Health Network Members, Providers shall follow the Health Network's Prior Authorization process.

E. A Practitioner shall not bill a Member for the provision of Covered Services in accordance with Medi-Cal requirements and in alignment with the terms and conditions of CalOptima Health Policy AA.1220: Member Billing.

F. A contracted Specialty Care Practitioner shall be credentialed in accordance with CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners.

G. Specialty Practitioner shall:

1. Preserve the dignity of the Member;

2. Verify a Member's eligibility at the time authorized services are provided;

3. Provide authorized services within their scope of practice;

4. After examination or provision of authorized treatment:

a. Advise the Member's PCP of findings and recommended treatment plan or follow-up care;

b. Provide a written report of findings and recommendations to the Member's PCP within ten (10) working days after rendering services to the Member;

c. Coordinate authorization with the Member's PCP or Health Network for additional tests or diagnostic studies necessary to complete their evaluation of the Member; and

d. Coordinate authorization with the Member's PCP or Health Network for any additional treatment or follow-up care that may be required.

5. Participate in, and accept continuing peer review of medical or surgical services;

6. Permit audit or review by the Member's Health Network, CalOptima Health or its agent, the California Department of Health Care Services (DHCS) or its subcontractors, a of those services provided to a Member;

7. Use the CalOptima Health or Health Network Grievance and Appeals procedures, as appropriate, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process, HH.1101: CalOptima Health Provider Complaint, MA.9006: Contracted Provider Complaint Process, and MA.9015: Standard Integrated Appeals; and

8. Designate a back-up Practitioner and provide a mechanism for a Member to access the back-up Practitioner when they are unavailable to provide care to the Member after initiation of treatment.

H. CalOptima Health and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.

III. PROCEDURE

A. A Specialty Practitioner shall request authorization for services for a CalOptima Health Member in accordance with this Policy and CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, GG.1508: Authorization and Processing of Referrals, and GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

B. A Specialty Practitioner may request a Standing Referral authorization in accordance with CalOptima Health Policy GG.1112: Standing Referral to Specialist or Specialty Care Center.

C. A Specialty Practitioner shall request authorization for services for a Health Network Member in accordance with the Health Network's authorization policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health, Health Network Service Agreement
E. CalOptima Health Policy AA.1220: Member Billing
F. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
G. CalOptima Health Policy GG.1112: Standing Referral to Specialty Care Provider or Specialty Care Center
H. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
I. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
J. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
K. CalOptima Health Policy GG.1510: Member Appeal Process
L. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
M. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
N. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
O. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
P. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
Q. CalOptima Health Policy MA. 9015: Standard Integrated Appeals
R. CalOptima Health Utilization Management Program Description

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/29/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/1998	GG.1113	Referral Practitioner Responsibilities	Medi-Cal
Revised	06/01/2007	GG.1113	Referral Practitioner Responsibilities	Medi-Cal
Reviewed	09/01/2014	GG.1113	Referral Practitioner Responsibilities	Medi-Cal
Revised	01/01/2016	GG.1113	Referral Practitioner Responsibilities	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2017	GG.1113	Referral Practitioner Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	08/01/2018	GG.1113	Referral Practitioner Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	GG.1113	Specialty Practitioner Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	10/01/2020	GG.1113	Specialty Practitioner Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	04/01/2021	GG.1113	Specialty Practitioner Responsibilities	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1113	Specialty Practitioner Responsibilities	Medi-Cal OneCare
Revised	12/31/2023	GG.1113	Specialty Practitioner Responsibilities	Medi-Cal OneCare
Revised	12/01/2024	GG.1113	Specialty Practitioner Responsibilities	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
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.
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.
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

Term	Definition
	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 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;

Term	Definition
	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.
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.
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), Licensed Midwife (LM) 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.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model program, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. 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.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialty Care Center	A center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
Specialty Care Provider	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.