Policy:	FF.1014
Title:	**Payment for Covered Services Rendered to a Member Enrolled in a Health Network**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 01/09/2025*
Effective Date:	12/01/2022
Revised Date:	09/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines Health Network payment methodologies for a Provider or Practitioner that provides Covered Services to a Member. This policy shall only apply to Covered Services in which the Health Network is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Non-contracted hospitals, non-contracted Practitioners, and non-contracted Ancillary Service Providers shall not be eligible to participate in any Health Network incentive payment programs.

B. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

C. The Health Network shall recover or reimburse overpayments in accordance with FF.2001: Claims Processing for Covered Services for which CalOptima Heath is Financially Responsible.

III. PROCEDURE

A. Hospital Payment: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse a hospital that provides Covered Services to a Member, as follows:

1. Contracted Hospital: Health Network reimbursement to a Contracted Hospital for Covered Services provided to a Member, shall be based on the Health Network contract with the Hospital.

2. Non-Contracted Hospital: Health Network reimbursement to a non-contracted hospital for Covered Services provided to a Member, that has received appropriate authorization, unless exempt from such authorization, in accordance with the Health Network's policy.

3. Outpatient Emergency and Non-Emergency Services: Health Network shall reimburse non-contracted outpatient Covered Services provided to a Member of the Health Network, at the same amount paid by the California Department of Health Care Services (DHCS) for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

4. Emergency Inpatient Services: A Health Network shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of the Health Network using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

5. Non-Emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between Health Networks and a hospital, a Health Network shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

6. Out of State Hospitals: a Health Network shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

    a. Border Hospital: A Health Network shall apply the DHCS State Plan Amendment (SPA) 15-020: Updates Year three Diagnosis Related Group (DRG) payment parameters for Out-of-State border hospitals changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, Health Network may pay a lower negotiated rate agreed to by the hospital.

7. Non-Emergency Non-Authorized Services: A Health Network shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with the Health Network's policy.

8. If a Member changes Health Networks, for purposes of this policy, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Heath Medi-Cal program. Subject to all applicable

Health Network policies, a Health Network shall reimburse a Practitioner providing Covered Services to a Member as follows:

1. Contracted Practitioner: Health Network shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and Health Network.

2. Non-contracted Practitioner: Health Network reimbursement to a non-contracted Practitioner for Covered Services provided to a Member, shall be based on the following:

3. Emergency Services: Health Network shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member of the Health Network, at one hundred percent (100%) of the CalOptima Heath Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

4. Non-Emergency Services: Health Network shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of the Health Network, for Covered Services for which the Health Network is financially responsible.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwives, licensed midwives, and Certified Nurse Practitioners services as permitted within each practitioner's scope of practice, the Health Network shall reimburse facility and professional services at one hundred percent (100%) of the Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program. If an appropriately licensed non-contracting free standing birthing center is used, CalOptima Health shall pay the center's facility.

D. Abortion Services: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall cover and reimburse the Providers of medical services and supplies incidental or preliminary to an abortion to a Member for which the Health Network is financially responsible.

E. Cognitive Assessments: Subject to all applicable Health Network policies, the Health Network shall cover and reimburse the Providers who provide cognitive health assessment services and follow-up services to Members aged sixty-five (65) or older who do not have Medicare coverage and provide necessary referrals to a Member under aged sixty-five (65) showing symptoms or showing signs of cognitive decline for which, the Health Network is financially responsible.

F. Doula Services: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall cover and reimburse the Providers of medical services and supplies incidental or preliminary to doula services to a Member for which the Health Network is financially responsible in accordance with CalOptima Health Policy GG.1707: Doula Services.

G. The Health Network shall reimburse diagnosis and treatment of a Sexually Transmitted Disease (STD) episode to a non-contracted provider including local health departments that provide treatment records or documentation of the Member's refusal to release Medical Records along with billing information at no less than the Medi-Cal FFS Rate.

H. The Health Network shall reimburse HIV Testing and counseling to a non-contracted provider who make reasonable efforts to report confidential test results, in accordance with applicable laws and regulations, including but not limited to Health & Safety Code Section 121025 at no less than the Medi-Cal FFS Rate.

I. Dyadic Care Services: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall cover and reimburse the providers of medical services and supplies incidental or preliminary to Dyadic Care Services to a Member under the age of twenty-one (21) for which the Health Network is financially responsible.

J. Street Medicine Services: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse Street Medicine Providers according to the Medi-Cal FFS for appropriate and applicable services within their scope of practice, in accordance with DHCS All Plan Letter (APL) 24-001: Street Medicine Provider: Definitions and Participation in Street Medicine Services. Street Medicine Providers must comply with the billing provisions for Street Medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider Manual, and in accordance with CalOptima Health Policy GA.7110: Street Medicine.

    1. If a Street Medicine Provider is an Federally Qualified Health Center (FQHC), they may be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located and are a billable clinic provider.

K. Telehealth Services: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse existing Covered Services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes, in accordance with DHCS APL 23-007: Telehealth Services Policy, and subject to any existing treatment authorization requirements and may be provided via a Telehealth modality in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology Enabled Services.

    1. To ensure proper payment and record of Covered Services provided via Telehealth, all Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through both synchronous interactions and asynchronous store and forward telecommunications. The rate of reimbursement, unless otherwise agreed to by the Health Network and the Provider will be the same rate, whether a Covered Service is provided in-person or through Telehealth.

L. Targeted Rate Increase (TRI): Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse eligible Provider types

for qualifying services at the TRI fee schedule rate, pursuant to paragraph 3 of Supplement 39 to Attachment 4.19-B of the California Medicaid State Plan, for dates of service on or after January 1, 2024.

1. FQHC and Rural Health Clinic (RHC) services do not qualify for reimbursement under the TRI Fee Schedule in the FFS delivery system and thus are not qualifying services for the purposes of this directed payment arrangement. The Health Network shall reimburse contracted FQHCs and RHCs in a manner that is no less than the level and amount of payment that the Health Network would make for the same scope of services if the services were furnished by another Provider type that is not an FQHC or RHC.

2. The Network Provider is reimbursed on a capitated basis, the Health Network shall ensure the Network Provider receives reimbursement that provides payment that is equal to, or projected to be equal to, the TRI Fee Schedule rate for applicable services at minimum.

3. The Health Network shall ensure that eligible Network Providers receive no less than the applicable minimum fee schedule rates for qualifying services.

    a. In instances where the Network Provider is reimbursed on a per-service basis, this requirement applies at the procedure code level.

4. Qualifying services are reported using the specified HCPCS and CPT codes and are appropriate for the services being provided and reported to DHCS in Encounter Data pursuant to DHCS APL 14-019: Encounter Data Submission Requirements.

5. The Health Network shall make available to the Network Provider an itemization of the reimbursement adjustments in an electronic format must for retroactive adjustments to per-service or capitated reimbursements made to a Network Provider.

M. Immunization: Welfare and Institutions Code (W&I) section 14132.968 added Pharmacist Services as a Medi-Cal benefit, reimbursable under the authority of State Plan Amendment 18-0039. Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse the initiating and administering of immunizations as a pharmacist service when rendered to a Member for which a Health Network is financially responsible for in the outpatient pharmacy setting by a pharmacist who is trained and operating under a Board of Pharmacy protocol, as authorized in B&P section 4052.8 and as described in 16 CCR section 1746.4, in the outpatient pharmacy setting are a reimbursable Medi-Cal benefit.

    1. The rendering pharmacist must be enrolled in Medi-Cal as an Ordering, Referring, and Prescribing (ORP) provider for claim reimbursement.

N. Clinical Trials: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall cover routine patient care costs for Members participating in a qualifying clinical trial including items and services furnished in connection with

participation by Members in a qualifying clinical trial pursuant to 42 United States Code (USC) Section 1396d(a)(30), and Welfare and Institutions (W&I) Section 14132.98.

1. A qualifying clinical trial is a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

2. Routine patient care costs are costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Medi-Cal program if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

3. A Provider, or Practitioner, shall obtain Prior Authorization for reimbursement of routine patient care costs related to a Health Network Member's participation in a Clinical Trial, in accordance with the policies established by the Member's Health Network.

O. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse an FQHC that provides Covered Services to a Member of the Health Network, for Covered Services for which CalOptima Heath is financially responsible, as follows:

1. Contracted FQHC: A Health Network shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and Health Network. A Health Network's contracted rates for an FQHC shall not be less than the Health Networks contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC: The Health Network shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of the Health Network, for Covered Services for which the Health Network is financially responsible at one hundred percent (100%) of the Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

    a. Health Network shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

P. American Indian Health Service Program Payment: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse an Indian Health Service Facility that provides Covered Services to a Member enrolled in a Health Network, for Covered Services for which the Health Network is financially responsible as follows:

1. Contracted American Indian Health Service Program:

a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, the Health Network shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and the Health Network and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with the Health Network, the Health Network shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, the Health Network shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: The Health Network shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, a Health Network shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. A Health Network shall ensure that the following criteria are met for receipt of payments:

   a. The American Indian Health Service Program Provider must be identified by DHCS;

   b. Except as provided in Section III.P.5. of this Policy, and as set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

      i. Medical health visit;

      ii. Mental health visit; and

      iii. Ambulatory visit.

5. Tribal FQHC: Effective January 1, 2021, the Health Network shall reimburse a Tribal FQHC Provider, including an Indian Health Care Provider enrolled as an Indian Health

Services Memorandum of Agreement (IHS-MOA) clinic that elected to participate in Medi-Cal as a Tribal FQHC Provider in accordance with the Alternate Payment Methodology (APM) and the following reimbursement requirements:

a. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent (80%) of the Medicare FQHC prospective payment system rate.

b. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."

c. The Health Network shall ensure that the following criteria are met for receipt of payments:

i. The Tribal FQHC Provider must be identified by DHCS;

ii. Service must be a Covered Service included in CalOptima Health's contract with DHCS;

iii. As set forth in DHCS All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers and California State Plan Amendment to Attachment 4.19-B, CA-20-0044, a Tribal FQHC Provider shall be reimbursed at the applicable rate for up to three (3) visits per day, per Member in any combination of different visits in the following visit categories:

a) Medical health visit;

b) Mental health visit; and

c) Ambulatory visit.

6. Certain Covered Services shall be reimbursed outside of the OMB or APM rate, including Non-Medical Transportation, Non-Emergency Medical Transportation, and pharmacy services.

Q. Ancillary Service Provider Payment: Subject to all applicable Health Network claims and utilization management policies, Health Network shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member for Covered Services for which Health Network is financially responsible as follows:

1. Health Network shall reimburse a contracted Ancillary Service Provider based on the terms and conditions of the contract between such contracted Ancillary Service Provider and Health Network.

2. Health Network shall reimburse a non-contracted Ancillary Service Provider for Covered Services rendered to a Member, at the Provider rate.

R. Financial Responsibility for Medically Necessary Post-Stabilization Services: Subject to compliance with all applicable Health Network claims and utilization management policies, including but not limited to, authorization, medical records, coding and billing requirements, Health Network financial responsibility for Medically Necessary Post-Stabilization Services provided to a Member are as follows:

1. Contracted Provider: Health Network is financially responsible for Medically Necessary Post-Stabilization Services rendered to a Member by Contracted Providers in accordance with their contract unless the contracting provider and contractor have agreed in writing to an alternate payment schedule.

2. Non-Contracted Provider: A Heath Network is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member that are pre-approved by the Health Network, as applicable.

3. A Health Network is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member that are not pre-approved by the Health Network, as applicable, but administered to maintain, improve, or resolve the Member's stabilized condition if:

a. The Health Network, as applicable, does not respond within thirty (30) minutes after receipt of a written request for Prior Authorization for Medically Necessary Post-Stabilization Services.

b. The Health Network, as applicable, cannot be contacted; or

c. A representative of the Health Network, as applicable, and the treating physician cannot reach an agreement concerning the Member's care.

S. A Health Network shall pay for all Medically Necessary health care services provided to a Member which are necessary to maintain the Member's stabilized condition up to the time that the Health Network, as applicable, effectuates the Member's transfer or the Member is discharged.

T. A Health Network's financial responsibility for Medically Necessary Post-Stabilization Services not pre-approved ends when:

1. The Health Network plan physician, as applicable, with privileges at the treating hospital assumes responsibility for the Member's care;

2. The Health Network plan physician assumes responsibility for the Member's care through transfer;

3. A representative of the Health Network, as applicable, and the treating physician reach an agreement concerning the Member's care; or

4. The Member is discharged.

U. Denial and Transfer: In the event that the Health Network denies a Prior Authorization request for Post-Stabilization Services from a non-contracted Provider, and transfers the Member to a contracted Provider, payment shall be made for Medically Necessary services furnished to the Member to maintain his or her stabilized condition up to the time that the Member's transfer is effectuated.

V. No Prior Authorization Request: If a non-contracted Provider does not seek a Prior Authorization request for Post-Stabilization Services from the Health Network, then the Health Network is only financially responsible for Emergency Services rendered, and not for Post-Stabilization Services.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Heath Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Heath Policy FF.2001: Claims Processing for Covered Services for which CalOptima Heath is Financially Responsible
C. California Health and Safety Code (HSC), §1797.1, and 121025
D. California Welfare and Institutions Code (WIC), §14105.28
E. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
F. Department of Health Care Services (DHCS) Policy Letter (PL) 96-009: Sexually Transmitted Disease Services in Medi-Cal Managed Care
G. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 14-019: Encounter Data Submission Requirements
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020: American Indian Health Programs (Revised 01/30/2024)
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives (Supersedes APL 16-003)

M. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (Supersedes APL 16-017)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020 (Supersedes APL 16-016)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers (Revised 01/30/2024)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-025: Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-029: Dyadic Services and Family Therapy Benefit (Revised 03/20/2023)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007: Telehealth Services Policy (Supersedes APL 19-009)
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001: Street Medicine Provider: Definitions and Participation in Managed Care (Supersedes APL 22-023)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services (Supersedes APL 22-022)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-007: Targeted Provider Rate Increases
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APL 18-004 and 16-009)
X. Department of Health Care Services (DHCS) State Plan Letter (SPA) 15-020: Updates Year three Diagnosis Related Group (DRG) payment parameters for Out-of-State border hospitals
Y. Manual of Current Procedural Terminology (CPT®), American Medical Association
Z. Social Security Act, §1932(b)(2)(D)
AA. Title 22, California Code of Regulations (CCR), §§51002, 55000 and 55140(a)
BB. Title 28, California Code of Regulations (CCR), §1300.71.4
CC. Title 42, Code of Federal Regulations (CFR), §422.113(c)
DD. Title 42, United States Code (USC), §1396d(a)(30), u-2(h)(2)(C)
EE. Welfare and Institutions (W&I) Code Section 14132.98

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/14/2022	Department of Health Care Services (DHCS)	Approved as File and Use
07/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/20/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Heath Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2022	FF.1014	Payment for Covered Services Rendered to a Member Enrolled in a Health Network	Medi-Cal
Revised	04/01/2023	FF.1014	Payment for Covered Services Rendered to a Member Enrolled in a Health Network	Medi-Cal
Revised	11/01/2023	FF.1014	Payment for Covered Services Rendered to a Member Enrolled in a Health Network	Medi-Cal
Revised	06/01/2024	FF.1014	Payment for Covered Services Rendered to a Member Enrolled in a Health Network	Medi-Cal
Revised	09/01/2024	FF.1014	Payment for Covered Services Rendered to a Member Enrolled in a Health Network	Medi-Cal

IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated by Indian Health Care providers with funds from the Indian Health Service (IHS) under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
Certified Nurse Midwife (CNM)	A registered nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Heath Members, the CHDP Program is incorporated into CalOptima Heath's Pediatric Preventive Services Program.
Covered Services	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-

Term	Definition
	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);

Term	Definition
	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.
Division of Financial Responsibility (DOFR)	A matrix that identifies how Health Network identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, Health Network and the County of Orange.
Emergency Services	Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning;

Term	Definition
	2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC section 1603.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 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

Term	Definition
	Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medical Record	The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Heath program.
Non-Emergency Services	Services provided by Providers that do not constitute an appropriate medical screening examination or stabilizing examination and treatment.
Post-Stabilization Services	Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. 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 Health Network for a Member enrolled in the Health Network for which Health Network is financially responsible for the Covered Services in accordance with the Division of Financial Responsibility.
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), Licensed Midwife, 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	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200. A Physician, Physician Assistant (under the supervision of a Physician), Certified Nurse Midwife, Licensed Midwife and Nurse Practitioner are authorized to dispense medications. Pursuant to California Business and Professions Code section 2725.2, if these contraceptives are dispensed by a Registered

Term	Definition
	Nurse (RN), the RN must have completed required training pursuant to Business and Professions Code section 2725.2 and the contraceptives must be billed with Evaluation and Management (E&M) procedure codes 99201, 99211, or 99212 with modifier TD (TD modifier as used for RN for (Behavioral Health) as found in the Medi-Cal Provider Manual.
Rural Health Clinic (RHC)	An entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.
Tribal Federally Qualified Health Center Provider or Tribal FQHC Provider	An Indian Health Care Provider operating under the authority of the Tribal Indian Self-Determination and Education Assistance Act and participating in Medi-Cal as a Tribal FQHC (using CMS criteria). California State Plan Amendment (SPA) 20-0044 establishes Tribal FQHCs provider type in Medi-Cal.