Policy:	GG.1500
Title:	**Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 11/22/2024*
Effective Date:	07/01/1997
Revised Date:	11/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

To define the process by which a Provider or Practitioner shall obtain authorization for Covered Services for a CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member, including Prior Authorization, Concurrent Review, and Retrospective Review.

II. POLICY

A. A Provider or Practitioner shall request Prior Authorization, Concurrent Review and Retrospective Review for Covered Services listed on the CalOptima Health Authorization Required List, available at www.caloptima.org, in accordance with this Policy, except as provided in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

1. A Provider or Practitioner requests authorization for elective inpatient services, elective outpatient services, elective ancillary services, and post-stabilization services after an emergency admission, prior to rendering such Covered Services to a Member.

2. A Provider or Practitioner may request retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request.

   a. One of the following conditions apply:

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

      ii. 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.

   b. Retrospective submission timeframe:

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

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

3. A Provider or Practitioner requests authorization for Covered Services rendered to a Member who is retroactively eligible for the CalOptima Health program within one hundred twenty (120) calendar days after the Member's retroactive eligibility determination is available in the State of California Beneficiary Eligibility Verification System.

B. CalOptima Health 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.1508: Authorization and Processing of Referrals, and GG.1535: Utilization Review Criteria and Guidelines.

C. Contracted and Non-Contracted Emergency Service Providers

1. 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 CalOptima Health.

2. Emergency Services are not subject to Prior Authorization by CalOptima Health, and CalOptima Health shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. CalOptima Health shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

a. 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. A plan health professional shall be available to the emergency room personnel treating the Member, for consultation and for general communication, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

C. A hospital shall notify CalOptima Health within twenty-four (24) hours of a Member's Initial Emergency Encounter in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

D. A Provider or Practitioner shall obtain authorization for the following services, in accordance with specified CalOptima Health policies:

1. Services for a Member who meets California Children's Services (CCS) eligibility criteria, in accordance with CalOptima Health Policy CalOptima Health Policy GG.1508: Authorization and Processing of Referrals;

2. Medical Supplies, in accordance with CalOptima Health Policies GG.1401: Physician Administered Drug (PAD) Prior Authorization Process, GG.1508: Authorization and Processing of Referrals, and MA.6101: Coverage Determination;

3. Disposable incontinence supplies, in accordance with CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies;

4. Durable Medical Equipment, in accordance with CalOptima Health Policy GG.1502: Criteria and Authorization for Durable Medical Equipment (DME), Excluding Wheelchairs;

5. Wheelchair rental, purchase, or repair, in accordance with CalOptima Health Policy GG.1531: Criteria and Authorization for Wheelchair Rental, Purchase, and Repair;

6. Non-emergency medical transportation and non-medical transportation, in accordance with CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical;

7. Hospice services, in accordance with CalOptima Health Policy GG.1503: CalOptima Health Hospice Coverage and Authorization Requirements;

8. Pharmacy services, in accordance with CalOptima Health Policies GG.1401: Physician Administered Drug (PAD) Prior Authorization Process, and MA.6101: Coverage Determination; and

9. Applied Behavioral Analysis (ABA) services and Psychological Testing, in accordance with CalOptima Health Policies GG.1548: Authorization and Monitoring of Behavioral Health Treatment Services and GG.1549: Authorization for Psychological Testing for Mental Health Conditions.

E. A Provider or Practitioner may appeal CalOptima Health's utilization management (UM) decision, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process, MA.9003: Standard Pre-Service Appeal, and MA.9004: Expedited Pre-Service Integrated Appeal.

F. 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.

G. 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.

H. CalOptima Health shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

I. CalOptima Health shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in section III.I. of this policy and in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals section III.A.

III. PROCEDURE

A. A Provider or Practitioner shall verify a Member's eligibility as follows:

1. Medi-Cal and CalOptima Health eligibility: In accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification; and

2. OneCare: Contact the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 and document the Eligibility Verification Confirmation number (EVC).

B. A Provider or Practitioner, including Specialist Physician, shall adhere to the responsibilities outlined in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

C. Authorization Requests

1. A Practitioner or Provider shall request the following authorizations in accordance with this 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 as described in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

2. A Provider or Practitioner shall submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department by:

   a. Mail to: Attn Utilization Management Department
   CalOptima Health
   PO Box 11033
   Orange CA 92856;

   b. Facsimile at 714-246-8579; or

   c. Phone: 1-888-587-8088.

   d. A contracted Provider may submit a routine, non-urgent authorization request online via CalOptima Health Link. The contracted Provider must upload medical documentation to CalOptima Health Link to support the Medical Necessity of the requested services.

3. If the request is urgent, the Provider or Practitioner must:

   a. Specify that the request is urgent on the ARF and fax to 714-338-3137; or

   b. Notify the CalOptima Health UM Department of the urgent request by telephone.

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

5. A contracted hospital shall notify CalOptima Health of a Member's inpatient admission within twenty-four (24) hours of the admission.

a. All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.

i. A decision will be made on an initial request within seventy-two (72) hours of receipt of the request.

ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:

a) Additional supporting clinical information is needed.

b. Concurrent clinical review shall continue throughout the inpatient stay.

i. If additional days are required a subsequent decision shall be made within seventy-two (72) hours of request or last covered day.

ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:

a) Additional supporting clinical information is needed.

c. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

D. Prior Authorization Request

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

a. A hospital must submit a Prior Authorization request for post-stabilization 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 for a post stabilization authorization are required to be fully documented. Documentation must 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 staff responding to the request.

c. A Prior Authorization request for Medically Necessary post-stabilization services shall consist of a completed and signed ARF from the facility to CalOptima Health 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:

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

ii. Name and role of facility clinician requesting Prior Authorization, 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;

c) Laboratory and/or radiology results;

d) Any available consultation notes; and

e) Physician progress notes.

v. Co-morbid conditions; and

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

d. For a Member enrolled in the Medi-Cal program, CalOptima Health shall approve or deny a Provider's Prior Authorization request for post-stabilization services within thirty (30) minutes after receipt of request that fully complies with Section III.D.1.b. of this policy. If CalOptima Health fails to approve or deny such request within thirty (30) minutes, Medically Necessary post-stabilization services are deemed approved.

i. Notwithstanding Section III.D.1.c. of this Policy, pursuant to section 1300.71.4 of Title 28 of the California Code of Regulations, CalOptima Health 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 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 of the Member's medical condition.

ii. In the case where CalOptima Health 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.

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

f. CalOptima Health shall pay for Medically Necessary hospital Emergency Services and post-stabilization services in accordance with CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible, and MA.3101: Claims Processing.

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

    a. For a Member enrolled in Medi-Cal, CalOptima Health shall approve or deny a Prior Authorization request for non-urgent care following an exam in an 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 CalOptima Health does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

E. Retrospective Authorization

1. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member by submitting the following to CalOptima Health's UM Department:

    a. Fully completed ARF;

    b. Evidence of OHC payment or denial, if applicable;

    c. Facility services:

        i. Itemized bill;

        ii. History and physical;

        iii. Discharge summary;

        iv. Progress notes;

        v. Physician's orders;

        vi. Operative report;

        vii. Emergency Department report, if applicable; and

        viii. Outpatient procedure report, if applicable.

    d. Outpatient professional services;

    e. Diagnosis related to services provided;

    f. Current Procedural Technology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes;

    g. Medical justification;

    h. Progress notes; and

    i. Procedure report.

2. CalOptima Health shall process a request for retrospective authorization within thirty (30) calendar days from receipt of the information that is reasonably necessary to make a determination in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals (Attachment A).

F. A Provider or Practitioner may request to modify an authorization prior to rendering services by contacting the CalOptima Health UM Department.

G. CalOptima Health shall process a request for authorization, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

H. CalOptima Health shall process a request for authorization of out-of-network and/or out-of-area services, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

I. Services Excluded from the Prior Authorization Process

1. No Prior Authorization is required for the following services:

a. Emergency services

b. Urgent care visits

c. Sensitive services (which include family planning)

d. Sexually transmitted disease services

e. Elective abortion

f. Minor consent services

g. Human Immunodeficiency Virus (HIV) testing

h. Basic prenatal care services

i. Routine obstetrics services

j. Pediatric preventive services, including any recommended routine immunizations

k. Primary and preventive care services, including any recommended routine immunizations

2. 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:

a. Advanced or metastatic stage 3 or 4 cancer; or

b. Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4 cancer.

c. A Provider or Practitioner shall submit:

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

ii. For fax authorizations where biomarker testing is requested, the Provider will attest to the stage 3 and 4 cancer diagnosis on the ARF.

IV. ATTACHMENT(S)

A. CalOptima Health Authorization Request Form (ARF) – Medi-Cal
B. CalOptima Health Authorization Request Form (ARF) – Behavioral Health Treatment
C. CalOptima Health Authorization Request Form (ARF) – OneCare

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Health, Health Network Service Agreement
C. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program
F. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
G. CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies
H. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
I. CalOptima Health Policy GG.1401: Physician Administered Drug (PAD) Prior Authorization Process
J. CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
K. CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
L. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Health Policy GG.1510: Member Appeal Process
N. CalOptima Health Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
O. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
P. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
Q. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
R. CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
S. CalOptima Health Policy GG.1549: Authorization for Psychological Testing for Mental Health Conditions
T. CalOptima Health Policy MA.3101: Claims Processing
U. CalOptima Health Policy MA.6101: Coverage Determination
V. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
W. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
X. CalOptima Health Utilization Management Program
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing
AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services

BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APLs 18-004 and 16-009)
CC. Health and Safety Code, Sections 1363.5 and 1367.01
DD. Title 22, California Code of Regulations, Sections 51003 and 51536
EE. Title 28, California Code of Regulations, Section 1300.71.4
FF. Title 42, United States Code, Section 139u-2(b)(2)(D)
GG. Title 42, Code of Federal Regulations, Section 438.404(a) and 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/28/2021	Department of Health Care Services (DHCS)	Approved as Submitted
08/23/2022	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/18/2024	Department of Health Care Services (DHCS)	File & Use

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	07/01/1997	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	05/01/1999	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	07/01/2007	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	09/01/2011	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	03-01//012	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	02/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	03/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	01/01/2016	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2017	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2018	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	03/01/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/03/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	09/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	08/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	04/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	11/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Applied Behavior Analysis (ABA)	Refers to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g., aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	For the 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 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 originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.
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.
CalOptima Health	For purposes of this policy, CalOptima Health means CalOptima Health Direct, including CalOptima Health Community Network (CHCN).
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.

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 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

Term	Definition
	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. 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.
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; 3. Serious dysfunction of any bodily organ or part; or 4. Death

Term	Definition
	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: 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). 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	For purposes of this policy, a Physician Hospital Consortium (PHC), , physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever comes first.
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

Term	Definition
	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.
Out-of-Area	Outside of the Service Area.
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.
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.

Term	Definition
Psychological Testing	The use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning.
Retrospective Review	The process of determining Medical Necessity after treatment has been given.
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Provider.