

Provider Manual

As of 11/10/2026

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7631 Wyoming St., Suite 201, Westminster, CA 92683, Tel: (714) 898-0765 ▪ Fax: (714) 898-0610

About Family Choice Medical Group

Family Choice Medical Group has been dedicated to providing the highest level of commitment and support for its physicians since 1984. Our goal is to provide the medical management services with the same high level of quality and integrity our physicians exhibit in patient care.
Moreover, Family Choice Medical Group lives up to its performance. Past audits have demonstrated routine referral turnaround in 48 hours, claims payment within 30 days, timely and accurate distribution of eligibility rosters and capitation payments. Family Choice Medical Group offers competitive rates as well as access to many Health Plan contracts.

Mission Statement

We provide the community with high quality health care in a courteous, compassionate manner to enhance the quality of life. In collaboration with hospitals and community, we provide preventive medicine and patient education.

Vision Statement

In the management and provision of health care, we will treat all patients with dignity and respect, forever advancing the quality of service for our patients by striving to exceed their expectations.

FCMS-Altura Management Services Contacts

Family Choice Medical Group

Physical Location: 1401 N. Montebello Blvd, Montebello, CA 90640

Physical Location: 7631 Wyoming St. Ste 201, Westminister, CA 92683

Claims/Mailing: PO Box 7280, Los Angeles, CA 90022-0980

Updated: 2/21/2025

General Contact Information			
Main Phone#: 800 611-0111			
Claims & Eligibility	**800 611-0111 Option 1,1**	**CONNECT Portal Support**	**800-611- 0111 Option 1,5**
Prior Auths	**800 611-0111 Option 1,2**	**Credentialing**	**800 611-0111 Option 1,6**
Inpatient Admisisons	**800 611-0111 Option 1,3**	**Contracting**	**800 611-0111 Option 1,7**
Outpatient Case Management	**800 611-0111 Option 1,4**	**Quality Management**	**800 611-0111 Option 1,8**
Electronic Claims Submission ID:		**95712 or FCMS2**	**Optum Exchange:** 95712

Departmental Contacts				
Name/Title	**Email**	**Phone**	**Fax**	
Executive Leadership				
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Dr. Tao Le, MD *Chief Clinical Officer*	tle@familychoice.com	714-351-8972	N/A	WESTMINISTER
Itsumi Fujiwara *Provider Relations Specialist*	ifujiwara@familychoice.com	714.675.5198	N/A	WESTMINISTER
Jyn Dao *Provider Relations Specialist*	jdao@familychoicemso.com	714.725.4301	N/A	WESTMINISTER
Utilization Management and Referral Process				
o Contracted Providers can access CONNECT FamilyChoicePortal to submit referrals o If unable to use CONNECT, fax the referral to **323-720-5608**				

Member Resources

Member Benefits

Covered Services include, but are not limited to, the following:

- Physician services
- Inpatient hospital care
- Inpatient mental health care
- Skilled nursing facility
- Home health care
- Hospice
- Chiropractic services
- Podiatry services
- Outpatient mental health care
- Outpatient substance abuse care
- Medically necessary ambulance services
- Non-emergency medical transportation
- Emergency services
- Urgent care
- Outpatient rehabilitation services
- Durable medical equipment
- Prosthetic devices
- Diagnostic tests, X-rays, lab and radiology services
- Prescription drugs
- Dental services
- Hearing services
- Vision services
- Health club membership/fitness classes
- Acupuncture and other alternative therapies

Member Rights and Responsibilities

You have the right to:

- Be treated with respect and dignity by all CalOptima, health network, and provider staff
- Privacy and to have your medical information kept confidential
- Get information about CalOptima, our health networks, our providers, the services they provide, and your member rights and responsibilities
- Choose a primary care provider (PCP) within CalOptima's network
- Talk openly with your health care providers about medically necessary treatment options, regardless of cost or benefit
- Help make decisions about your health care, including the right to say “no” to medical treatment
- Voice complaints or appeals, either verbally or in writing, about CalOptima or the care we provide
- Get oral interpretation services in the language that you understand
- Make an advance directive
- Access family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and emergency services outside CalOptima's network
- Ask for a State Hearing, including information on the conditions under which your State Hearing can be expedited
- Have access to your medical record, and where legally appropriate, get copies of, update or correct your medical record
- Access minor consent services
- Get written member information at no cost in braille, large-size print and other formats upon request and in a timely manner appropriate for the format being requested
- Be free from any form of control or limitation used as a means of pressure, punishment, convenience or revenge
- Get information about your medical condition and treatment plan options in a way that is easy to understand
- Make suggestions to CalOptima about your member rights and responsibilities
- Freely use these rights without negatively affecting how you are treated by CalOptima, providers or the state

Your responsibilities

- Knowing, understanding and following your member handbook
- Understanding your medical needs and working with your health care providers to create your treatment plan
- Following the treatment plan you agreed to with your health care providers
- Telling CalOptima and your health care providers what we need to know about your medical condition so we can provide care
- Making and keeping medical appointments and telling the office when you must cancel your appointment

- Learning about your medical condition and what keeps you healthy
- Taking part in health care programs that keep you healthy
- Working with and being polite to the people who are partners in your health care

Member Billing Restrictions

The Department of Health Care Services (DHCS) and CalOptima Health have specific guidelines restricting the billing of CalOptima Health members by providers. This section describes the general prohibition on billing members for covered services, as well as the restrictions governing when a provider may bill a member.

BILLING MEMBERS FOR COVERED SERVICES IS PROHIBITED

DHCS prohibits providers from charging members for Medi-Cal-covered services or having any recourse against the member or DHCS for Medi-Cal-covered services rendered to the member.

- The prohibition on billing of the member includes, but is not limited to:
    a. Covered services
    b. Covered services provided during a period of retroactive eligibility
    c. Covered services once the member meets his or her share of cost requirement
    d. Co-payments, coinsurance, deductible or other cost sharing required under a member's other health coverage
    e. Pending, contested or disputed claims
    f. Fees for missed, broken, cancelled or same-day appointments
    g. Fees for completing paperwork related to the delivery of care (e.g., immunization cards, WIC forms, disability forms, sports physical forms, or history or physical forms that are required by a school, medical forms for Department of Motor Vehicles (DMV) requirements, PM160 Well-Child Visit form, lead testing questionnaire and forms related to Medi-Cal eligibility.) Please refer to Policy AA.1220 for additional information.
- A provider who accepts a member as a patient must accept payment in full from CalOptima Health, its health network, medical group or third-party administrator for covered services.

LIMITED CIRCUMSTANCES IN WHICH THE MEMBER MAY BE BILLED

A provider may bill a member only for services not covered by Medi-Cal, if:

- The member agrees to the fees in writing prior to the actual delivery of the non-covered services
- A copy of the written agreement is provided to the member and placed in his or her medical record
- The rendering provider is not registered with Medi-Cal.

FACTS ABOUT THE MEMBER BILLING RESTRICTIONS

- Providers should always verify a CalOptima Health member's eligibility prior to rendering covered services and, if applicable, obtain appropriate prior authorization in accordance with CalOptima Health Policies and Procedures.

- With the exception of required co-payments or Medi-Cal share of cost, a participating provider should not bill, seek reimbursement or attempt to collect payment from a CalOptima Health member or the member's representative for covered services.
- With the exception of required co-payments or Medi-Cal share of cost, a non-participating provider should not bill, seek reimbursement or attempt to collect payment from a CalOptima Health member or the member's representative for authorized, urgent or emergent covered services.
- Providers should not collect payment (check, cash or credit card) for services rendered in lieu of billing a claim to CalOptima Health, its health network, medical group or third-party administrator.
- Providers should not bill a member for a claim that has been denied due to lack of authorization or due to untimely filing. Providers are solely responsible for seeking authorization of services and for submitting claims in a timely manner.
- Providers should never ask a CalOptima Health member to inquire about the status of a claim. The provider's staff cannot involve the member in any of the steps to collect payment from CalOptima Health.

Member Complaints and Grievances

I. Scope

This policy applies to (1) Family Choice Management Services (“FCMS”) and its subsidiaries and affiliates (each, an “Affiliate”); and (2) any other entity or organization in which Family Choice Management Services or an Affiliate owns a direct or indirect equity interest of 50% or more (collectively, the “Company”). Member Services Department

II. Purpose

To define the process for handling of member formal complaints and grievances and appeals when the Medical Group/IPA is not delegated for both routine and expedited requests and to ensure that there is a full and fair process for resolving members’ disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service when this process is delegated.

III. Definitions

Appeal: Any of the procedures that deal with the review of adverse Organization Determinations related to health care services that an enrollee believes he or she is entitled to receive. This includes delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the enrollee. It also relates to any amounts the enrollee must pay for a service. These procedures include Reconsideration by the MA Plan and if necessary, an independent review entity (IRE), hearing before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

For Medicare members, an Appeal is any request received by the organization where the initial request was denied for lack of clinical documentation and the provider resubmitted the request with clinical documentation within 60 days of the date of the initial decision to deny. These requests are forwarded to the corresponding health plan as an Appeal. Requests received by the organization where the initial request was denied for lack of clinical documentation and the provider resubmitted the request with clinical documentation after 60 days of the date of the initial decision to deny are not considered Appeals and are processed by the organization as a new request. Appeals are forwarded to the MA plan within 24 hours of receipt.

For the purpose of this policy, the term Appeal refers to both commercial and Medi Cal appeals and Medicare Reconsiderations.

Team Member: Includes only employees of Family Choice Management Services.

IV. Policy Statement:

This Policy applies to client(s) of Family Choice Management Services to the extent formally adopted by such client(s). The activities described in this Policy will be performed by the party assigned herein to perform such activity or, to the extent such responsibility is not expressly assigned herein, as set forth in the applicable services agreement between Family Choice Management Services and the applicable client.

Family Choice Management Services affiliated IPA's are not delegated to handle member complaints/ grievances and appeals. It is our policy, however, to inform members of their right to file a formal complaint/grievance or appeal with their health plan.

V. Procedure:

A. When the Grievance and Appeal Process is not Delegated

Family Choice Management Services affiliated IPA's are not delegated to handle member complaints/ grievances and appeals. It is our policy, however, to inform members of their right to file a formal complaint/grievance or appeal with their health plan.

Should a member call the Member Services Department wishing to file a formal complaint against a provider or a service, the Member Services Rep will use the following script:

> **"I am sorry but I am unable to take a formal grievance/appeal regarding a provider or a service in our network. If, however, you would like to file a formal complaint/grievance/appeal, please contact the number on your health plan membership card. The health plan will be happy to help you and will take the proper procedures to ensure that your inquiry is handled properly."**

If the member is with CalOptima OneCare, the member services agent will warm transfer the member to CalOptima's customer services department. The agent will remain on the line until a CalOptima customer service agent accepts the call. The agent will then document call in the Incident module using Type QIC (Quality Grievance) and Subtype CSP (Cust Serv/Provider Off) that include who the call was connected with.

Should a member fax a formal grievance or appeal including but not limited complaints against the office staff and complaints regarding cultural and linguistic services (whether expedited or routine), the

Grievance Specialist will immediately send the request via facsimile to the relevant health plan within 48 hours of receipt. Documentation provided must include if received in writing or verbally, who received from, date received, and issue. Grievances for Anthem members must be forwarded to the plan within 1 business day of receipt.

All expedited appeals are referred to the health plan Grievance and Appeal Department immediately. All standard appeals will be referred to the health plan Grievance and Appeal Department within 24 hours of receipt. For SCAN and Easy Choice Medicare Advantage plans, all grievances are forwarded to the healthplan within 24 hours. Documentation provided must include if received in writing or verbally, who received from, date received, and issue. Please note ALL Quality of Care (QOC) issues to include sentinel events are to be sent to the health plan immediately within 1 business day after receipt. Documentation provided must include if received in writing or verbally, who received from, date received, and issue.

The Medical Group/IPA must work in coordination with the relevant health plan to obtain and submit any documentation requested of the Medical Group/IPA or its network providers to assist in the resolution of grievances or appeals coordinated by the health plan, including but not limited to clinical information. For expedited appeals, records will be sent within 24 hours or sooner. For standard appeals, records will be sent within 7 calendar days. All responses to requests must comply with health plan and regulatory requirements for turnaround times for both standard and expedited grievances.

All transplant appeals are referred to and handled by the Health Plan

Health plan grievance and appeal forms are available in practitioner offices. Providers can contact the customer service department to obtain a copy of the health plan grievance form and a copy is available on the provider portal. The IPA has sent and makes this information available to contracted practitioners on the web. The complaint form provides an opportunity for the member to request a conference as part of the grievance system.

The UM delegate refers the member to United HealthCare as follows:

Upon receipt of a written request for appeal, the UM delegate immediately notifies United HealthCare and submits it via FAX. - If the member calls the UM delegate,

the delegate makes a warm transfer of the enrollee directly to the plan’s Member Services number on the enrollee’s card. During that call, the delegate informs UHC’s Member Services of the exact date and time the UM delegate received the enrollee’s call. The policy also states that members will have continued coverage for covered services, pending the outcome of an appeal. This applies only to covered services.

Capitated Provider Administrative Guide states:

Medical group/IPA's responsibilities related to Customer grievance and appeals Participating providers are required to:

• Immediately, within 1 hour of receipt, forward all Customer grievances and appeals complaints, appeal, quality of care/service concern, whether oral or written) to United HealthCare West for processing at:

- Written grievance/appeal – contact information included in the How to Contact Us Reference Table, set forth under the Expedited Customer appeals and Standard Customer appeals sections; Oral grievance/appeal – contact information included in the How to Contact Us Reference Table, set forth under the Expedited Customer appeals and Standard Customer appeals sections. For Medicare Advantage products:

  United HealthCare Appeals and Grievances Department
  P.O. Box 6106
  MS: CA124-0157
  Cypress, CA 90630
  Fax: (888) 517-7113

United Healthcare's request for information such as the complete original UM file when UHC has received an appeal request regarding and adverse organization determination or NOMNC.
Provide UHC with proof of effectuation within the stipulated timeframes on reversals of adverse determinations.
Turnaround times for both appeals and reversal of adverse determinations, with no exception for weekends and holidays:

For expedited appeals, within two (2) hours of request for records
For standard appeals, within 24 hours request for records

For Anthem commercial, Urgent Grievance requests must be sent to the health plan within one hour of receipt.

B. When the Grievance and Appeal Process is Delegated

All member complaints and appeals including pre-service appeals, post-service appeals and expedited appeals are received through the customer service, toll free line and logged by a customer service representative. The log includes Member name and ID number, nature of the complaint, nature of resolution and name of the staff member who took the call and resolved the complaint. This includes both medical necessity and benefit appeals. The customer service rep created an incident in the EZ Cap Customer Service Module and routes it to the Quality Specialist for resolution.

RESPONSIBILITY: Member Services Department, Quality Specialist

Must post a Notice of Non-Discrimination that informs members, potential members, and the public about non-discrimination and accessibility requirements. The notice of Non-Discrimination must be posted in a conspicuously visible font size and be included in significant publications and significant communications targeted to members, potential members and the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures

VI. Enforcement

All Team Members whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject Team Members to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VII. References

None

Appeals Process for Service or Care Decisions

I. Scope

This policy applies to (1) Family Choice Management Services and its affiliated and/or related entities; and (2) any other entity or organization in which Family Choice Management Services or an Affiliate owns a direct or indirect equity interest of 50% or more (collectively, “FCMS”).

II. Purpose

The purpose is to ensure that when function is delegated, all appeal requests are appropriately processed and that the review process complies with all regulatory, state, Medicare and health plan requirements. All appeals must be handled promptly and investigation must be conducted with oversight by management or supervisory staff responsible for the service or operations that are the subject of the appeal. The process is to ensure that there is a full and fair process for resolving pre-service and post-service appeals.

When appeals are not delegated, the health plan is responsible for processing member appeals.

III. Definitions

Team Member: Includes only employees of Family Choice Management Services.

IV. Policy Statement

A. Appeals

1. An Appeal is a request to change a previous decision made by the Medical Group/IPA.
2. All preservice, postservice and expedited Appeals, and Appeals to an independent review for medical necessity and benefit appeals processing must be registered.
3. The IPA/Medical Group shall immediately refer all medical quality of care issues to the Health Plan’s Medical Director or Designee for review.
4. A Preservice Appeal is a request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the Member obtaining care or services. A Member’s request for an Appeal of a denial for service excluded from the health plan benefit package is a Preservice Appeal if the Member has not received the requested

services. In this case, the Member may not receive coverage for the requested care or service unless the Medical Group/IPA approves it.

5. A Postservice Appeal is a request to change an adverse determination for care or services that have already been received by a Member.
6. The Appeals process shall address the receipt, handling, and disposition of Member Appeals, in accordance with applicable statutory, regulatory, and contractual requirements.
7. An expedited Appeal is a request to change an adverse determination for urgently needed care. Urgently needed care is any request for medical care or treatment with respect to which the application of the time period for making the non-urgent care determinations could result in the following:
    a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, or
    b. In the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
8. If the IPA/Medical Group receives an Appeal that involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function, it shall process such Appeals as an expedited UM Appeal:
    A. Shall utilize specialist consultants, as appropriate.
    B. Shall notify the Member of the limited time available for the ember to present evidence and allegations of fact or law, in person and in writing.
    C. Shall make a decision on the Expedited UM Appeal request as quickly as the medical condition requires, but no later than seventy-two (72) hours after the Expedited UM Appeal request is made to the IPA/Medical Group and provide verbal notice of the resolution of the expedited review to the Member.

D. Shall notify the Member or the Member's Authorized Representative, and all involved Providers of the Expedited UM Appeal decision by facsimile or verbal communication within seventy-two (72) hours after receiving the Expedited UM Appeal. The IPA/Medical Group shall provide a written notice within one (1) business day after a verbal notice

E. Shall take immediate action to implement the decision, in accordance with the Expedited UM Appeal.

9. An external appeal is a request for an independent, external review of the final adverse determination made by the organization through its internal appeal process.

10. Appeals include internal appeals based on medical necessity and benefit determinations related to coverage or to the provision of care or services, with the exception of external appeal requirements, which apply only to medical necessity appeals.

11. Appeals for a denial of clinical services require participation of health care professionals with appropriate expertise.

12. The Member or Authorized Representatives may act on behalf of Members at all levels of appeals with respect to appealing an adverse determination. The Quality Specialist shall determine upon receipt of the appeal whether an individual is acting as the Member's Authorized Representative. Members may choose who they ask to represent them, including an attorney.

13. A Member or a Member's Authorized Representative may file an Appeal with the IPA/Medical Group:

    a. By telephone

    b. In Person

    c. Facsimile

    d. In Writing

14. The Medical Group/IPA continues coverage during the appeal process for Preservice appeals, Postservice appeals, Expedited appeals, & External appeals. The IPA Medical Group must not discriminate against a Member based on the Member filing an appeal.
15. The IPA/Medical Group shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.
16. For Medicare enrollees, a representative appointment by an enrollee (not by court order or acting in accordance with state law) is considered valid for one year after its effective date (signature date by both participants – enrollee and representative). To be appointed by an enrollee, both the enrollee making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form. Upon receipt of a request for organization determination from someone other than the Member or treating physician, the IPA/ Medical Group will obtain appropriate legal documents to demonstrate that the requesting individual is the enrollee's assigned representative.- For each request for an organization determination, the delegate must request and make reasonable efforts to obtain the appropriate documents regarding enrollee's appoint representative.
17. The IP/Medical Group shall give a Member, the Member's Authorized Representative, or provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Appeal, evidence, testimony, facts and law in support of his or her Appeal and shall inform of the limited time available to present evidence with sufficient advanced notice of the resolution timeframes, including expedited.
18. Member and Authorized Representative most be notified, in writing, that the grievance, organization determination, or reconsideration request will not be considered until the appropriate documentation is provided. For expedited requests, the Quality Specialist monitors the grievance in the customer service system to ensure that expedited requests are not inappropriately delayed. When a request for a grievance, organization determination, or reconsideration is filed by a person claiming to be a representative, but the representative does not provide appropriate documentation upon request, the IPA/Medical Group must make, and

document, its reasonable efforts to secure the necessary documentation. The IPA/Medical Group must not undertake a review until or unless such documentation is obtained. The time frame for acting on a grievance, organization determination, or reconsideration request commences when the documentation is received.

19. The IPA/Medical Group shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by the Member, his or her Authorized Representative, or provider, acting on behalf of the Member with the Member's written consent, at no cost.
20. The IPA/Medical Group shall allow a Member, a Member's Authorized Representative or provider, acting on behalf of the Member with the Member's written consent, to file a Grievance when he or she disagrees with a decision to extend the timeframe for resolution of an Appeal or expedited Appeal.
21. Benefit coverage for Members who have submitted an appeal remains in effect during the appeal process.
22. The Medical Group/IPA allows a health care practitioner with knowledge of the Member's condition, such as the treating physician or the Member's primary care physician, to act at the Member's Authorized Representative.
23. A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The IPA/Medical Group shall grant the Member continuation of the benefit until an Appeal decision is reached.
24. The IPA/Medical Group follows CMS (Medicare) and state-specific requirements.
25. When the IPA/Medical Group is not delegated for appeals, the IPA/Medical Group must forward the appeal request to the contracted health plan within 48 hours of receipt of the appeal.
26. The IPA/Medical Group shall designate a manager with authority to require corrective actions to be responsible for receiving Appeals, issuing Appeal decisions, and reporting to the health plans.

B. Preservice Appeals

1. The Medical Group/IPA allows at least 180 calendar days after notification of the adverse determination for a Member or Member's Authorized Representative to file an Appeal
2. The Quality Specialist must document the substance of the preservice appeal and any actions taken.
3. The Quality Specialist, in cooperation with a different Medical Director who was not involved in the prior adverse decision conducts a full investigation of the substance of the appeal, including any aspects of clinical care involved and documents findings.
    a. Complaint staff shall promptly consult with the department responsible for the services or operations that are the subject of the Appeal.
    b. If the a request for an expedited Resolution of an Appeal is denied, the IPA/Medical Group must process the request for an Appeal in accordance with the standard Appeal process timeframes.
    c. The complaint staff shall review the factual findings, proposed resolution, and any other relevant information, and shall issue a Notice of Appeal Resolution to respond to the Appeal.
    d. The IPA/Medical Group shall send the Member a Notice of Appeal Resolution as quickly as the Member's health condition requires, but not later than thirty (30) calendar days after receipt of an oral or written Appeal, except as otherwise provided in Section III.A.4 of this policy.
4. The Member has the opportunity to submit written comments, documents or other information relating to the appeal.
5. The Medical Group/IPA appoints a new person to review a preservice appeal who is a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment who was not involved in the initial determination and is not a subordinate of any person involved in the initial determination, for medical necessity appeal and if deciding on a grievance regarding denial of an expedited resolution of an Appeal and any Appeal involving a clinical issue.

6. It is required that for all Urgent Referral Requests, the physicians and the Member, must be notified of their Expedited Appeal Rights within 24 hours of the denial determination.
7. The decision for a preservice appeal and notification to the Member must be completed within 30 calendar days of receipt of the request.
8. The notification to the Member includes information about further appeal rights.
9. The Quality Specialist provides reasonable access to and copies of all documents relevant to the Member's appeal free of charge to the Member upon request.
10. A Medical Director who was not involved in the initial preservice adverse decision/determination as either the decision maker or the subordinate of any person involved in the initial denial reviews appeals.
11. An appeal may be extended only if the Member voluntarily agrees to extend the appeal time frame or if Federal program regulations allow the organization to request additional information from the Member. If the appeal does not qualify for an extension, the organization must make the appeal decision with the allotted time frame based on the information available.

C. Postservice Appeals

1. The Medical Group/IPA allows at least 180 calendar days after notification of the adverse determination for a Member or Member's Authorized Representative to file an Appeal
2. The Quality Specialist must document the substance of the Postservice Appeal and any actions taken.
3. The Quality Specialist and Medical Director conduct full investigation of the substance of the appeal, including any aspects of clinical care involved and documents findings.
4. A new person is appointed to review Postservice Appeals who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination.
5. A Medical Director who was not involved in the prior adverse decision is appointed to review Postservice Appeals who is a practitioner in the same or a similar specialty that typically treat the condition, performs the procedure or provides the treatment for medical necessity decisions.

6. The Member has the opportunity to submit written comments, documents or other information relating to the Appeal.
7. The Medical Group/IPA appoints a new person to review a postservice appeal who is a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment who is not the subordinate of any person involved in the initial determination.
8. It is required that for all Urgent Referral Requests, the physicians and the Member, must be notified of their Expedited Appeal Rights within 24 hours of the denial determination.
9. The decision for a postservice appeal and notification to the Member must be completed within 60 calendar days of receipt of the request.
10. The notification to the Member includes information about further appeal rights.
11. The Quality Specialist provides reasonable access to and copies of all documents relevant to the Member's appeal free of charge to the Member upon request.
12. A Medical Director who was not involved in the prior adverse decision as either the decision maker or the subordinate of the decision maker of the initial denial reviews appeals.
13. The Medical Group/IPA must all an Authorized Representatives to act on behalf of Members, including an attorney, at all levels of appeals, including postservice appeals.
14. An appeal may be extended only if the Member voluntarily agrees to extend the appeal time frame or if Federal program regulations allow the organization to request additional information from the Member. If the appeal does not qualify for an extension, the organization must make the appeal decision with the allotted time frame based on the information available.

D. Expedited Appeal Rights including Pre-Service Appeals

1. It is required that for all Urgent Referral Requests, the physicians and the Member, must be notified of their Expedited Appeal Rights within 24 hours of the denial determination.

2. If it is not possible to get the letters delivered to the physicians and the Member within 24 hours of the denial, a phone call must be made and documented in the EZCap notes field under the header “APPEAL RIGHTS”.
3. The notes must include the time, date, and the contact person. This note must be part of the supporting documentation when creating the formal denial letter.
4. For appeals involving clinical issues, including appeals about whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care practitioner who has appropriate training and experience in the field of medicine involved in the case must review the appeal. This is referred to as same-or-similar specialist. The same specialty refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A similar specialty refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems. Depending on the type of case, the same-or-similar specialist may be a physician, behavioral healthcare practitioner, chiropractor, dentist, physical therapist or other type of practitioner, as appropriate.
5. The Medical Group/IPA must offer Members an expedited appeal for any urgent care requests and must have policies and procedures outlining the mechanism for initiating and processing an expedited appeal in the event that an expedited appeal is necessary.
6. The Medical Group/IPA must make the expedited appeal decision and notify Members and practitioners as expeditiously as the medical condition requires, but no later than 72 hours after the request. An expedited review begins when a Member, the Member’s Authorized Representative or a practitioner acting on behalf of the Member requests an expedited appeal. A Medical Group/IPA with two levels of appeal for urgent care issues is required to complete the entire process within the 72 hour timeframe. The 72 hour time period may be suspended when the 1st level of appeal is completed. It begins again if a second appeal on the same issue is received.
7. The Medical Group/IPA must grant an expedited review to all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

8. The Medical Group/IPA's policies and procedures must allow a practitioner to appeal on a Member's behalf, and must describe the process for rendering decisions and providing notification to the Member and practitioner within the specified time frames. For expedited appeals, the organization may notify practitioners only of the decision, since NCQA assumes that the treating or attending practitioner is acting as the Member's Authorized Representative.
9. The organization may provide an initial oral notification of an expedited appeal decision to the practitioner within 72 hours of receipt of the request. It must send a written notification to the Member and practitioner no later than 3 calendar days after the initial oral notification.

E. Two Levels of Internal Appeal

1. A Medical Group/IPA may have two levels of internal appeal. The 180-calendar-day allowance for filing an appeal only applies to first level appeals. The Medical Group/IPA must provide Members with a reasonable amount of time to pursue the second level of appeal.
2. A Medical Group/IPA with two levels of internal appeal must complete both levels within the time frame specified for the type of appeal under review. NCQA does not require the Medical Group/IPA to split the time equally. The Medical Group/IPA's policies and procedures must specify the amount of time allotted to each level of internal appeal. For example, the Medical Group/IPA may allocate 10 days to complete first-level appeals and 20 days to complete second-level appeals for pre-service appeals. While NCQA accepts splitting the appeals time frame unequally, this may not be compliant with federal DOL requirements.
3. If state Medicaid regulations require the Medical Group/IPA to maintain two required levels of internal appeal for Medicaid Members, NCQA reviews the pre-service first-level Medicaid appeals using the 30-calendar-day time frame that applies to organizations with a one-level appeal process.
4. If the Medical/Group IPA has two levels of internal appeal, its policy must state at which level it includes the same-or-similar specialist review. NCQA does not require the review to occur at both levels when there are two levels of internal appeal. However, NCQA reviews the UM appeal files for evidence of occurrence of same-or-similar-specialist review, as specified within the Medical Group/IPA's policies and procedures, and scores the files accordingly in UM 12, Element C.

F. Two Levels of Internal Appeal

1. A Medical Group/IPA that offers voluntary levels of appeal beyond the required internal appeal process must describe the voluntary appeal procedures and inform Members how to obtain additional information about such procedures when it notifies them of the appeal decision.

2. The Medical Group/IPA must agree that any statute of limitations or other defense based on timeliness is suspended while a voluntary appeal is pending.

G. Bypassing Internal Appeal Review

1. With a member's permission, the Medical Group/IPA may refer an appeal directly to an independent review organization (IRO) without conducting an internal review.

H. Using an IRO for same-or-similar Specialist Review

1. The Medical Group/IPA may contract with an IRO to provide same-or-similar specialists as consultants during the internal appeal process. For cases referred for external review a specialist who was involved in the internal appeal process may not review the case again.

I. Written or Electronic Appeal Decision Notifications

1. The Medical Group/IPA must be resolved the appeal and provider the Member with written or electronic notification of the decision within 60 calendar days of the request.
2. The decision includes the specific reasons in easy to understand language and culturally and linguistically appropriate manner, a reference to the benefit provision, guideline, protocol or other similar criterion on which the decision was based and notification that the Member can obtain free of charge, upon request, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based with any new or additional evidence.
3. The Member notification includes a notice that the Member can obtain, upon request, reasonable access to and copies of all documents relevant to the appeal at no charge to the Member. Relevant documents include documents or records considered, relied on or generated

by the organization including any documents and records submitted in the course of deciding the appeal.

4. The notices includes the title of each reviewer for a benefit appeal or the title, qualifications and specialty (ie MD, DO, PhD) of each reviewer for a medical necessity appeal. The letter must specifically state the listed individuals participated in the appeal review. Participant names do not need to be included in the written notification to Members, but must be provided to Members upon request.
5. The letter includes a description of the next level of appeal, either within the organization or to an external organization, as applicable, along with any relevant written procedures (appeal rights are required whenever the Medical Group/IPA makes a decision that is adverse to the Member). If the Medical Group/IPA completely overturns the denial, the appeal notice must state the decision and the date. For Medicare Members, the Customer Service Department representatives make outbound calls to Members to notify them of the appeal decision and that the upheld notice was sent to Maximus.
6. The Medical Group/IPA must allow Members to be represented by anyone they chose, including an attorney, to act as an Authorized Representative to act on behalf of the Member.

J. Letter Content

1. The Medical Group/IPA provides written notification to the member.

2. The notification of the appeals process to Members is written in a culturally and linguistically appropriate manner for all levels of appeals including preservice and postservice and contains a description of the Appeal Rights and that the Member has 180-calendar days from receipt of the denial notice to request an appeal including the right to submit written comments, documents or other information relevant to the appeal and an explanation of the appeal process, including the right to Member representation and time frames for deciding appeals. Medicare Members have 60 calendar days to file an appeal from the denial notification date.

3. If the notification is a denial of an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process must be included. This applies to behavioral health notifications when the group is delegated for behavioral health, including Cal Optima Healthy Families. A

description of the expedited appeal process must be included whether the request is Urgent or not. MediCal does not have the same criteria. An expedited appeal can be requested by the Member or the provider “when the Member believes, or the provider determines, that the proposed therapy would be significantly less effective if not promptly initiated.” (CalOptima P&P GG. 1510)

4. The notification letter includes a description to the Member of the opportunity to seek an independent medical review from the DMHC of disputed health care services if the Member believes that health care services have been modified, improperly denied or delayed by the Medical Group/plan or one of its contracting providers if the decision was based on findings that the proposed service(s) is not medically necessary. The DMHC has specific language required in the denial letters to Commercial Members for their IMR. This process applies to commercial and Healthy Families Members.

5. The notification letter includes information about the appeals process. Notification to Medi-Cal Members must include information on the Member’s right to a State Fair Hearing and directions on filing such a hearing.

6. The Medical Group/IPA uses a standardized DHS and Health Plan approved letter template to notify Members and providers of denied, delayed, modified and terminated requests that includes the following:

    a. The action taken, the reason for the action taken and a citation of the specific UM criteria, regulations or health plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity.

    b. Member’s right to, and method of obtaining, a state fair hearing to contest the decision.

    c. Member’s right to represent himself/herself at the state fair hearing or be represented by legal counsel, friend or other spokesperson.

    d. The time limit for requesting a state fair hearing.

e. Member’s right to an expedited state hearing (ESH) in cases where the enrollee’s health plan or provider indicates that the time for a standard resolution could seriously jeopardize the enrollee’s life, health, or ability to attain, maintain or regain maximum function.

f. Notice that the Member may use the health plan's Complaint/Grievance process prior to or concurrent with the initiation of the state fair hearing process;

(i) The health plan's Complaint / Grievance process information, including the address and telephone number;

(ii) Information re: Department of Managed Health Care (DMHC) complaint process;

(iii) The Member's right to obtain an Independent Medical Review (IMR) through the Department of Managed Health Care (DMHC);

(iv) Expedited appeals language (for urgent and inpatient requests).

g. The telephone number for the local Legal Aid Society.

h. For expedited appeals, notification must indicate that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

7. The Medical Group/IPA uses the most current ICE approved templates. When denying a requested service whether it is based on benefit or medical necessity, the written notifications will contain the following:

a. The specific reason(s) for the denial, in easily understandable language.

b. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.

c. Notification that the Member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.

d. Notification to the requesting or requested provider that the physician reviewer is available to discuss any UM denial decisions including the telephone number of the physician reviewer.

e. Notification of how to obtain a copy of the criteria used to make referral determinations as well as how to contact the physician reviewer is made to physicians through the provider newsletter, the provider manual and on the website. A copy of the decision making criteria can be obtained by calling the Customer Service Department at (800) 611-0111.

8. The IPA/Medical Group shall maintain written records of each Appeal, including at least the following information:

    a. Date of receipt

    b. Member's name

    c. Nature of the Grievance or Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations as well as;

    d. Untimely assignments to providers;

    e. Issues related to cultural and linguistic sensitivity; Difficulty accessing specialists; and Grievances related to out-of-network requests.

    f. Names of staff who received the Appeal and who is designated as the contact person, description of the Appeal.

V. Enforcement

All Team Members whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject Team Members to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

Provider Resources

Claims Submission and Payment

Claims and Encounter Submission

Physician shall submit Claims and Encounter Data on a monthly basis, within thirty (30) calendar days of the date of service. Such data shall be sufficient in order for IPA to characterize the content and purposes of each encounter with an Enrollee.

Physician further agrees to submit such Encounter Data on an original CMS 1500 form or other form (including electronic transfer) designated by IPA. Such form is required to be complete in all aspects, including IPA name, complete coding (CPT, HCPCS, ICD 10 CM), itemization, date of service, billed amounts, health plan, subscriber number, and authorization/referral numbers when required by IPA and which otherwise meets IPA's requirements as set forth in the IPA provider reference manual. Failure to timely submit those statements shall be a material breach of this Agreement and grounds for IPA to: (a) terminate this Agreement; (b) suspend the ability of Enrollees to select or be assigned to Physician; or (c) limit or reduce Physician's maximum enrollment level. Physician agrees to certify that Encounter Data submitted is complete and truthful.

Provider Billing & Reporting

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for Medi-Cal HMO, Senior HMO, Commercial HMO, POS, and, where applicable, PPO products where **Family Choice Medical Group** is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Section 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

I. Claim submission instructions.

A. Sending Claims to **Family Choice Medical Group** Regarding Claims. For claim filing requirements or status inquiries, you may contact **Family Choice Medical Group** by calling: (800) 611-0111.

Via Mail: PO Box 7280
Los Angeles, CA 90022-0980

Via Family Choice Portal: connect.familychoiceportal.com

Connect Portal support: 800-611-0111 Option 1,5

Via Clearinghouse: Accepted Electronic Claims Clearinghouse:

1. Office Ally - (866) 575-4120 Payer ID: 95712 or FCMS2
2. Emdeon - (615) 932-3356 Payer ID: 95712 or FCMS2
3. MDX – (562) 256-3800 Payer ID: 95712 or FCMS2
4. Capario – (949) 852-3491 Payer ID: 95712 or FCMS2

B. Calling **Family Choice Medical Group** Regarding Claims. For claim filing requirements or status inquiries, you may contact **Family Choice Medical Group** by calling: (800) 611-0111

C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by **Family Choice Medical Group.**
Contracted providers have a minimum of 90 calendar days from the date of service to submit a complete clean claim. "Complete Claim" means a claim or portion thereof, including attachments and supplemental information and documentation, which provide reasonably relevant information or information necessary to determine payment liability. For institutional providers a claim must be submitted on a UB92: The complete UB92 data set or its successor format adopted by the National Uniform Billing Committee (NUCB), submitted on the designated paper or electronic format as adopted by the NUCB; entries stated as mandatory by the NUCB and required by federal statute and regulations; and any state designated data requirements included in statutes and regulations. For Physician and other Physician providers: The center for Medicare and Medicaid Services. Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Physician Providers must be on a CMS 1500 claim form. No more than six lines can be submitted on a CMS. For referred and/or ordered Services the name of the referring or ordering Physician and the NPI or UPIN numbers must be present in box 17 and 17A. Current Procedural Terminology (CPT) codes and modifiers and the International Classification of Diseases (ICD-9CM) codes. Coding requirements must include the following appropriate coding: CPT Level I codes; Appropriate CPT and or HCPCS modifiers; HCPCS National Level II codes; HCPCS Local Level III codes; ICD-9-CM.

D. Claim Receipt Verification. For verification of claim receipt by **Family Choice Medical Group**, please do the following:

1. Log onto to www.connect.familychoiceportal.com and select

claim, inquiry option;
2. Requesting an electronic register of receipts from Clearing house for electronic submissions; or
3. Call (800) 611-0111 to request claim status.

E. Fee Schedules. Contracting providers may access fee schedule information on the FCMS web site at www.familychoice.com. Refer to your Specialty Care, Ancillary or Primary Care Services Agreement to determine which fee schedule to use, the percentage of the fee schedule, and the region used to determine allowable reimbursement for services provided.

E. Payment Guidelines. **Family Choice Medical Group** adjudicates claims according to AMA, CPT-4, HCPCS, ICD-10, Centers for Medicare and Medicaid Services and Medi-Cal guidelines as well as industry standards. McKesson Claim Check is a software application that used to review all Physician provider claims submitted to the IPA for possible coding or other billing errors. If a claim submitted to IPA differs from the Claim Check logic, the claim will be modified with an explanation on the remittance advice issued to you. Medical justifications on adjudication determinations are also provided through Clear Claim Connection and available on the FCMS web site at www.familychoice.com.

Claim Overpayments

A. Notice of Overpayment of a claim. If **Family Choice Medical Group**. determines that it has overpaid a claim, ***Family Choice Medical Group.*** will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which ***Family Choice Medical Group***. believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

B. Contested Notice. If the provider contests ***Family Choice Medical Group'***s notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to ***Family Choice Medical Group***. stating the basis upon which the provider believes that the claim was not overpaid. ***Family Choice Medical Group.*** will process the contested notice in accordance with ***Family Choice Medical Group'***s contracted provider dispute resolution process described in Section II above.

A. No Contest. If the provider does not contest ***Family Choice Medical Group'***s notice of overpayment of a claim, the provider must reimburse ***Family Choice Medical Group*** within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

B. Offsets to payments. ***Family Choice Medical Group*** may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when: (i) the provider fails to reimburse ***Family Choice Medical Group*** within the timeframe set forth in Section IV.C. In the event that an overpayment of a claim or claims is offset against the

provider's current claim or claims pursuant to this section, ***Family Choice Medical Group***. will provide the provider with a detailed written explanation identifying the specific overpayment of payments that have been offset against the specific current claim or claims.

Prior Authorization Process

FCMG performs utilization management functions, including referral authorization, to promote the provision of medically appropriate care and to monitor, evaluate and manage the cost effectiveness and quality of health care delivered to our members.

FCMG conducts prospective review to evaluate referrals for specified services or procedures that require authorization. Authorization determinations made by licensed review nurses are based on medical necessity and appropriateness and reflect the application of approved review criteria and guidelines. Physician review and determination is required for all final denial decisions for requested medical services. The review of the denial of a pharmacy prior authorization may be by a qualified physician or pharmacist. Medicare/Medi-Cal members are an exception to the pre-authorization requirement, as Medicare is the primary payer in these instances. If a provider requests services for members enrolled in a CalOptima health network, the provider will submit the request for authorization to the member's health network.

HOW TO REQUEST AUTHORIZATION FOR SERVICES 1. The provider should first verify the member's eligibility with FCMG. For potential retroactive eligibility, the provider should check the Medi-Cal eligibility system systems monthly.

Obtaining Authorization for Medical Services: The provider should submit the referral to the FCMG Utilization Management department via Family Choice Portal at connect.familychoice.portal.com..

TIME FRAMES FOR MEDICAL AUTHORIZATION 1. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency 2. Post-stabilization: Upon receipt of an authorization request from an emergency services provider, FCMG shall render a decision within 30 minutes, or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4 3.

Family Choice Medical Group
Direct Referral Form

PATIENT INSTRUCTIONS

1. **Make an Appointment:** Call the specialist or provider listed below to schedule your appointment.
2. **Bring This Form:** Take this form with you to your appointment and give it to the office staff. This form is called a Direct Referral form because the services listed below do not need prior approval.
3. **Bring Medical Records:** Bring all your medical records to the appointment, including test results, x-rays, ultrasound reports, or MRIs.

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Health Plan:** _____ **Health Plan ID:** _____

REFERRING PROVIDER INFORMATION

Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **Date Seen:** _____

REFERRED TO SPECIALIST/ANCILLARY PROVIDER INFORMATION

Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **Specialty:** _____

RENDERING PROVIDER INSTRUCTIONS

1. **Verify Eligibility:** Authorization is based on the patient's eligibility at the time of service. Please verify the patient's eligibility before providing services.
2. **Perform Listed Services:** Only perform the services listed on the form. If additional care is needed, contact the UM Department at 800-611-0111 or fax the request with relevant medical records, reports, and test results to 323-720-5608.
3. **Submit Forms:** Attach a copy of this form to the CMS 1500 form and send it to: P.O. Box 7280, Los Angeles, CA 90022-7280.
4. **Interpreter Services:** Free interpreter services are available for members with limited English proficiency or hearing impairments. Call the Member Services Department of the member's health plan for assistance.
   Return Reports: Please return the consult report and any other pertinent information to the requesting provider and/or PCP.

Primary Care Provider & Fax *(If different than Requesting Provider)*: _____

Requesting Provider Signature: _____

On the following page, please indicate the services needed based on the Preventive Services Information Guide located on the Connect Provider Portal which provides a full listing of services that are considered preventive and/or are exempt from prior authorization and therefore may utilize the Direct Referral Form (*https://connect.familychoiceportal.com/*)

Family Choice Medical Group
Direct Referral Form

Please indicate the services needed based on the Preventive Services Information Guide located on the Connect Provider Portal for a full listing of services that are considered preventive and/or are exempt from prior authorization and therefore may utilize the Direct Referral Form:

SERVICES NEEDED (SELECT ONE & ADD CPT CODE)	
c **Family Planning Services**	**CPT Code(s):**
c **Basic Prenatal Care**	**CPT Code(s):**
c **Direct Access to Women's Services**	**CPT Code(s):**
c **Preventive Services**	**CPT Code(s):**
c **Behavioral Health**	**CPT Code(s):**
c **Dietician**	**CPT Code(s):**
c **Neurology – Sleep Study (Medi-Cal ONLY)** Applicable if the following are documented: 1. Suspected sleep apnea, or severe sleep disturbances 2. A sleep center study should be conducted if a member is suspected of having sleep apnea despite a low probability. Additionally, a sleep center is appropriate if there are issues with conducting a home study, mental health concerns, other medical conditions, or if the patient is a child	**CPT Code(s): 95810 or 95811**
c **Other: _____**	**CPT Code(s):**

REASON FOR REQUEST

Important Notice: *Please be aware that sensitive services, family planning, preventive services, and other services exempt from prior authorization have specific age and gender requirements. For detailed information, kindly refer to the Preventive Services Information Guide.*

Conflict Resolution

Dispute Resolution Process for Contracted Providers

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to **Family Choice Medical Group** and /or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

i. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim form **Family Choice Medical Group** to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;

ii. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and

iii. If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. Sending a Contracted Provider Dispute to **Family Choice Medical Group**..
Contracted provider disputes submitted to **Family Choice Medical Group** must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of **Appeals Department** at **Family Choice Medical Group** that handles contracted provider disputes at the following:

Grievances and Appeals: (213) 410-2163

C. Time Period for Submission of Provider Disputes.

(i) Contracted provider disputes must be received by **Family Choice Medical**

Group. within no later than three hundred sixty five (365) days from provider's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or

(ii) In the case of inaction, contracted provider disputes must be received by no later than three hundred sixty-five (365) days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

(iii) Contracted provider disputes that do not include all required information as set forth above in Section II.A. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to **Family Choice Medical Group, Inc.** within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. Acknowledgment of Contracted Provider Disputes. **Family Choice Medical Group** will acknowledge receipt of all contracted provider disputes as follows:

i. Electronic contracted provider disputes will be acknowledged by **Family Choice Medical Group** within two (2) Working Days of the Date of Receipt by Family Choice Medical Group

ii. Paper contracted provider disputes will be acknowledged by **Family Choice Medical Group** within fifteen (15) Working Days of the Date of Receipt by **Family Choice Medical Group**

DI. Contact ***Family Choice Medical Group***. Regarding Contracted Provider Disputes.
All inquiry regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to ***Family Choice Medical Group***. at: (800) 611-0111

DII. Instructions for Filing Substantially Similar Contracted Provider Disputes.
Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

i. Sort provider disputes by similar issue
ii. Provide a cover sheet for each batch, using the Dispute Resolution Form included with this notice
iii. Number each cover sheet
iv. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets

DIII. Time Period for Resolution and Written Determination of Contracted Provider Dispute. ***Family Choice Medical Group***. will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

DIV. Past Due Payments. If the contracted provider dispute or amended contracted provider

dispute involves a claim and is determined in whole or in part in favor of the provider, ***Family Choice Medical Group***. will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

Dispute Resolution Process for Non-Contracted Providers

A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to ***Family Choice Medical Group***. challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain at a minimum, the following information: the provider's name, the provider's identification number, contract information, and:

i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from ***Family Choice Medical Group***. The following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect.

ii. If the non- contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider's position on the dispute, and enrollee's written authorization for provider to represent said enrollees.

B. Dispute Resolution Process. The dispute resolution process for non-contracted providers is the same as the process for contracted Providers as set forth in sections II.B., II.C., II.D., II.E., II.F., II.G., and II.H. above.

Provider Dispute Resolution Process – Medicaid Advantage

I. Purpose

Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) expanded its current provider payment dispute resolution process for disputes between non-contracted and deemed providers and Private Fee for Service Plans to include disputes between non-contracted providers and all:

1. Medicare Advantage Organizations (HMO, PPO, RPPO and PFFS)
2. 1876 Cost Plans
3. Medi-Medi Plans
4. Program of All-Inclusive Care for the Elderly (PACE) organizations.

Non-contracted providers must accept as payment in full payment amounts applicable in Traditional Medicare. The Medical Group/IPA imposes a cap on payments to non-contracted providers of: provider payment amounts plus beneficiary cost-sharing amounts applicable in Traditional Medicare. Non-Contracted providers are prohibited from balance billing MA plan enrollees for other than MA plan cost-sharing amounts. Non-contracted providers are subject to penalties if they accept more than traditional Medicare amounts.

All Medicare Advantage provider disputes must be managed to 30 Calendar days of original receipt date.

1. Interest required on a reprocessed non-contracted provider clean claim if the group made an error on the original organization determination; and
2. Interest only applied on the additional amount paid; and
3. Interest calculated FROM the 'oldest receive date of the original claim'
UNTIL the 'check mail date' of the additional amount paid.

II. Definitions

Team Member: Includes only employees of Family Choice Management Services.

Medicare Provider Dispute is a non-contracted provider's written dispute for alleged underpayment.

III. Policy Statement

It is the policy of FCMS VBC that all Provider Disputes will be processed according to regulatory requirements for all managed Medical Groups/IPAs. When paying, contesting, adjusting or denying a claim, FCMS VBC will notify the provider of the provider dispute process on the EOB describing their right to file a formal dispute in writing, including information on where to send the dispute and where to obtain a copy of the Provider Dispute Resolutions form.

Provider Disputes may be received via the following methods and are forwarded to the mailroom upon receipt to be batched and inventoried:

1. The Claims P.O. Box
2. Through the Health Plan Demand Process
3. Email
4. Fax
5. Customer Service Department Faxes

If a call to file a dispute is received in the customer service department, the representative will advise the caller that a written dispute must be submitted to the designated P.O. Box for proper tracking and handling. If the caller refuses to submit a written request, the call and outcome will be documented in a newly created claim record in EzCap and will be flagged as an Appeal received telephonically and will not be processed as a PDR. The customer service rep will advise the provider that a copy of the PDR form is available at www.capcms.com.

It is the policy of Family Choice Management Services that all requests received from providers in writing will be identified as a PDR. Any verbal request received through the Customer Service area will be flagged in EzCap as an adjustment (Appeal).

The adjusters are responsible to ensure that all PDR and Appeal files they review, including those received as health plan demand notices, are correctly classified and not rely solely on mailroom for the correct classification.

The Claims Manager monitors the inventory and aging of all provider disputes received throughout the various intake areas mentioned above through a daily inventory and aging report.

IV. Procedure

1. Registration will enter disputes as follows:
    a. Individual disputes will be batched and vertexed in MACESS and in-loaded into EZ cap
2. Disputes must be acknowledged as follows:
    a. Paper claims within 15 working days
    b. Electronic claims within 2 working days

CMS PDR – Effective Septembr 18,2020:

1. Applies to only Non-Contracted Providers
2. Includes decisions where a non-contracted provider contends that the amount paid by the payer for a covered services is less than the amount that would have been paid under Original Medicare.

Effective September 18, 2020 – <u>CMS PDR DOES NOT INCLUDE</u>:

1. Payment denials by payers that result in zero payments being made to to a non-contracted provider
2. Payment disputes for contracted providers.
3. Local and National Coverage Determinations.
4. Medical necessity determinations.
5. Payment disputes for which no initial determination has been made.

Regulatory Guidance:

1. See §§1852(a)(2)(A) of the Act for Medicare Advantage plans; 1876 for Cost plans; and 1866(a)(1)(O) for PACE organizations. 42 C.F.R. § 422.566(b)(3), 42 C.F.R. § 422.574(b), 42 C.F.R. § 422.578, 42 C.F.R. Part 422, Subpart M

Submission of a <u>first level</u> Provider Dispute must be filed within 120 calendar days after the notice of initial determination (i.e. EOB's/ RA's/ Letters) to file the reconsideration.

1. Payer may allow an additional 5 calendar days for mail delivery.
2. Regulations at 42 CFR 405.940-405.942

Extension of Time Limit for Filing a CMS Provider Dispute – Good Cause:

1. When a provider or supplier has failed to establish a good cause for late filing of a provider dispute, the payer dismisses the provider dispute as untimely filed.
    a. Resolution must explain the reason for dismissal and that the provider or supplier has up to 180 calendar days from the date of the dismissal notice to provide additional documentation for good cause.
    b. If provider or supplier submits evidence within 180 calendar days of dismissal that supports a finding of good cause for late filing, the payer makes a favorable good cause determination and issues a redetermination.
    c. If the payer does not find good cause, the dismissal remains in effect and payer issues a letter or EOB/RA explaining that good cause has not been established.

Requesting Documentation for Review of the CMS Provider Dispute:

1. If documentation has not been submitted for review of the Provider Dispute, payer may request that required documentation is submitted
    a. Request can be made via phone or in writing.
2. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the payer conducts the review based on the information in the file.

In the event the documentation is received after the 14-calendar day deadline, the payer must consider the evidence before making and issuing the final determination.

Time Frame for Making a CMS Payment Dispute Decision:

1. Payers' decision on the Payment Dispute must be within 30 calendar days from the date the Payment Dispute is first received by the payer.
    a. Must be in writing
    b. Include facts and rational pertaining to the resolution
    c. Inform provider about their right to the MAO-Health Plan or designee, Provider Dispute Resolution (Second Level) review process.
    d. 30 Calendar Day TAT based on:

1. Decision in provider favor = Mail Date of Payment/Letter
2. Decision upheld = Letter Mail Date

2. Regulatory Guidance:
    a. Sections 1852(k) and 1894(b)(3) of the Act and CMS regulations at 42 CFR §§422.214, 417.558 and 422.520

CMS Provider Dispute Resolution Letter Format:

1. Provider Dispute correspondence shall follow these recommended guidelines:
    a. Use at least 12-point font/type
    b. Use an easy-to-read font style
        i. Examples - Universal or Times New Roman
2. If procedure codes are cited, the actual name of the procedure must be associated with the code – services should not be abbreviated

Registration will enter disputes as follows:

1. Disputes are batched and vertexed in MACESS using PDR as a procedure code and in-loaded into EZ cap.
2. Medicare Advantage disputes are segregated into a separate work queue

Second Level Payment Dispute Resolution:

1. The non-contracted provider may submit a second level written request to the applicable MAO-Health Plan or designee for a second level review, by email, fax or mail within 180 calendar days of written notice from the payer.
2. The Second Level request may be filed if:
    a. 30 calendar days has elapsed from the date the payer received the payment dispute, and the payer has not responded.
3. The MAO-Health Plan or designee may request documentation from the payer that processed the first level provider dispute.

Retaining Documents and Records:

1. Copies of all provider disputes and corresponding documentation must be kept for a period of not less than ten years.
2. Regulatory Guidance
    a. 42 C.F.R § 422.504

Payment of Interest:

- **Effective May 1, 2011; CMS Region IX** has reviewed its policy with respect to payment of interest on disputed claims, including claims from non-contracted providers. Interest must be paid on such claims in the same manner as provided for all other claims. If the original claim was underpaid in error, then interest would be required on the additional amount of the payment due, from the date of the original claim (oldest date received) until the date the claim was reprocessed. Interest would be calculated in the same manner as interest on all claims, which is discussed in the Medicare Claims Processing Manual, Section 80.

Additional information on the calculation of late interest penalties including examples can be accessed on the Prompt Pay Web site at http://www.fms.treas.gov/prompt/formulas

Adjusters Will:

1. Work the Medicare Advantage Payment Dispute queue first in / first out based on original received date.
2. Verify that the dispute meets the criteria – that dispute is for non-contracted provider dispdisputing Medicare underpayment

If the dispute is not related to –

- Diagnosis code/DRG payment denials.
    - An NCP submits a claim to an MAO. The MAO initially approves the claim, which is considered a favorable organization determination (see 42 C.F.R. 422.566(b)). The MAO later reopens and revises the favorable organization determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds.
- Down-coding.

    - An MAO approves coverage for inpatient services from a NCP, which is considered a favorable organization determination (see 42 C.F.R. 422.566(b)). The MAO later reopens and revises the favorable organization determination (e.g., retrospective review) and determines the enrollee should have received outpatient services.
- Bundling issues and disputed rate of payment.
    - Pre- and post-pay bundling and global payment determinations. For example, denial of procedure codes -- as mutually exclusive to another paid procedure code, or due to inclusion in a previously paid global surgical package.
- Level of care or rate of payment denials.
    - Payment of a reduced fee schedule amount for a course of treatment. For example, a provider bills a procedure code for a visit but the MAO reimburses based on a lower level of care.
- Decisions where a non-contracted provider contends that the amount paid by the payer for a covered service is less than the amount that would have been paid under Original Medicare.
    - If a disagreement is limited to the amounts a NCP could collect if the beneficiary were enrolled in original Medicare pursuant to § 422.214(a)(1), this issue would be subject to the plan's internal payment dispute process.

The above examples are scenario examples only and do not represent an all-inclusive list of scenarios that should be considered an appeal versus a dispute.

The adjuster will modify the procedure code from PDR to APEAL and change the UDF2 field to APPEAL and process the claim through as an appeal.

When necessary documentation has not been submitted for review of any Provider Dispute related to,or due to bundling, the payer must advise the provider to submit the required documentation. Request can be made via phone or in writing. If documentation is not received within 14 calendar days from date of request, the payer conducts review based on information in the file. If the documentation is received after the 14 calendar day deadline, the payer must consider the evidence before making and issuing the final determination.

If a PDR is nearing non-compliance and the dispute still needs to be developed or reviewed by the medical director, a nearing non compliance report is monitored hourly and the leads or department manager will walk or email the request to the correct department for immediate response. A phone call is immediately

placed to the provider or medical group in the event additional information is required in order to complete the PDR.

If the dispute is related to underpayment, the adjuster will review the documentation included with the dispute, verify the rates paid on the initial determination with the rates currently in the system. If the rates in the EZ Cap system are higher than the rates paid on the initial determination, the claim will be overturned and adjusted accordingly. Interest on overturned provider disputes will be calculated only on the additional amount paid. If the rates paid on the initial determination are correct, the dispute is upheld. If the adjuster determines that the rate paid on the initial determination is greater than the Medicare fee schedule, adjuster must confirm proper rates with T&C before finalizing the dispute and flag for recovery.

The Terms and Conditions Contract Analyst will review the request from the adjuster and audit the system against the Medicare fee schedule to ensure that the EZ-CAP system is loaded with the correct rates for the date of service as well as the provider locality. If the rates loaded in the system are not correct based on the Medicare fee schedule for the date and locality, the Contract Analyst will update the system accordingly. Once the Contract Analyst has determined whether or not the system is setup to pay the correct rate for the claim in question, the Contract Analyst will flag the claim with a processing status code of TCOR if the system is correctly pricing or TSUP if the system has been updated. Processing status codes are tracked and trended in order to identify potential system issues or training potential.

If the dispute is overturned, the adjuster enters adjustment and final adjustment and the provider receives a resolution letter. These resolution letters are faxed. For contracted providers fax numbers are found in the provider's contract and for non-contracted providers fax numbers are found at https://npiregistry.cms.hhs.gov/search.

If the dispute is upheld, the adjuster enters adjustment and final adjustment codes as outlined below:

	Adjustment Code	Final Adjustment
Per Medical Review	50	ADMR
Paid at Medicare Rates	B13	URCR
		AUMD
Information not Received	16	DRI
PDR not timely	29	PPDTF

All 2nd Level Disputes received in error by VBC are forwarded to the health plan for processing upon receipt. These disputes are coded with an adjudication code of B11/FHP and forwarded as outlined in policy CL 1059.

APPEALS/PDR PROJECTS

When an issue is identified through the adjusters, the finance department, or through the Network Directors, the issue is reported and logged into the weekly PAC Committee log. For Medicare appeals projects, an adjuster reviews the log to determine if the appeal is related to an incorrect rate payment, or bundled service. If the issue meets the criteria and was submitted by the provider, the adjuster will treat the Medicare appeal as a PDR.

If the claims are determined to be appeals and not provider disputes, the adjuster adjudicates the claims to determine if there is system configuration problem. If yes, the issue is reported and logged in the Customer Service module and reported to the T&C department for system and contract audit. If system configuration or contract interpretation is found to be incorrect by T&C, the system is corrected and a report is generated to re-process all of the claims previously paid. The report is emailed to the Project Specialist and the project is logged into the Project Tracker spreadsheet. The provider configuration and any changes or updates to the project status are discussed and reviewed at the weekly PAC Committee meetings where the re-work of the claims is tracked and reported.

PROVIDER MONITORING

A monthly report of provider disputes by provider is reviewed monthly as a root cause analysis to identify opportunities to reduce volume. Issues related will be presented to and tracked to resolution by the PAC Committee.

COMPLIANCE MONITORING

Random PDR accuracy audits are conducted retrospectively by the compliance and claims department daily to ensure the proper identification, processing and finalization of PDR claims are accurate.

Daily PDR pre-check audits are conducted by the quality department as outlined in policy QC1003 and QC1005.

During the audit process when a PDR is determined to have an accuracy error, the auditor goes into the ***Processing Status Code*** field and enters the appropriate code along with an explanation in the free form text box if needed.

CPDR	Not a True PDR
CLTR	Letter Accuracy
FDRCV	Wrong Received Date Used Interest Incorrectly Paid
FINT	ER Interest Not Paid Correctly
FPEN	Penalty Due Not Paid
CACE	Incorrect Adjudication (incorrectly upheld, incorrectly overturned)

The auditor is also required to enter an additional Processing Status code of PAUDIT on all PDRs reviewed regardless of whether or not an error was identified. This provides the ability to track the volume of PDR's audited and establish an accuracy rate based on all PDRs audited. Crystal Reports are used to monitor, track and trend findings from provider dispute processing audits. Audit results are reported monthly.

All errors identified through pre and post check run audits are reported on the monthly monitoring, tracking and trending log, and are used as training material for adjusters, customer service representatives, auditors and health plan demand staff. The Compliance Manager or designee conducts the training monthly for current and new FTEs.

New hires for claims, quality control, health plan demand customer service staff will receive HICE PDR 101 training within 30 days or hire. The HICE PDR 101 training will be conducted semi-annually for all employees in the aforementioned job functions.

V. Enforcement

All Team Members whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject Team Members to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include

modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. References

Health Industry Collaborative Effort (HICE) website under Approved HICE Documents.

Note: EASY CHOICE

1. All first level disputes for Easy Choice must be forwarded to the healthplan for processing

Note: All Aetna appeals MUST be forward to Aetna Health Plan for processing

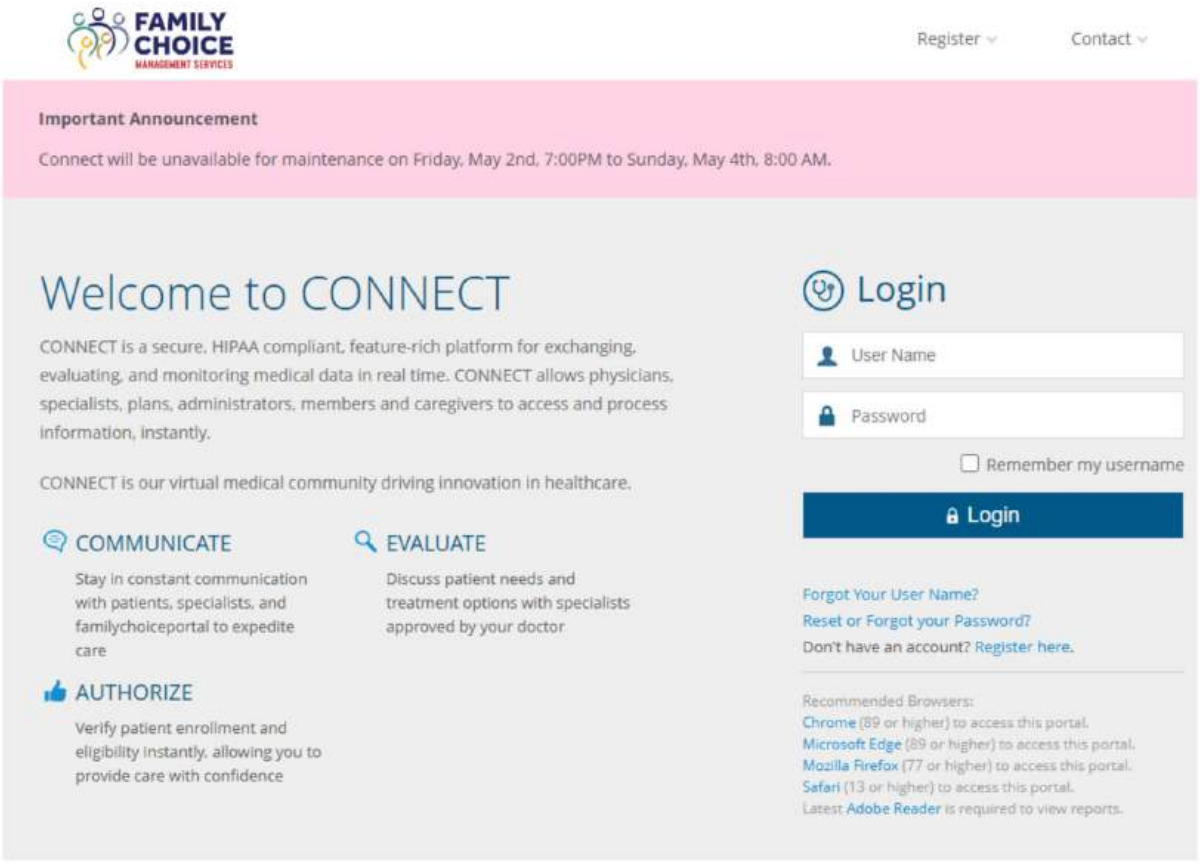
Connect FamilyChoice Portal Training

Login

Go to https://connect.familychoiceportal.com

Click “Login”

Input provider user name and click “Login”



For all Connect issues please contact them at 800-611-0111 Option 1,5

“Provider offices and practitioners are responsible for checking the provider web portal on a regular basis to review notifications and updates.”

Member Eligibility

To determine member eligibility, go to the site and click “Directory, Member Eligibility Search”

Input member information and click “Search”

General Information

For forms, hover over “Provider Resources” and click “forms”

To submit a referral, hover over “Referrals” and click “Referral Request”

For claims, hover over “Claims” and click “Claims Payment Inquiries”

Critical Incident Reporting

PURPOSE
There are a number of mandatory abuse reporting statutes applicable to vulnerable populations. Specific State agencies are responsible for the investigation of them. The IPA/Medical Group will work with medical and community care providers and member care givers in establishing a safe environment and take appropriate action in response to incidents which affect or have the potential to affect, the health, safety, or wellbeing of the IPA/Medical Group members and member caregivers. The reporting of critical incidents by providers is an important ongoing monitoring tool to assess network and case-specific member safety issues.

DEFINITIONS
Critical Incident: "Critical Incident' is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a health plan client and/or his or her caregiver.

Reportable Critical Incidents Defined
1. Abuse
2. Neglect
3. Exploitation
4. Rights Violations
5. Serious Injury
6. Missing Person
7. Death
8. Emergency Situation
9. Medical Emergency
10. Medication Error
11. Restraints and Seclusion
12. Suicide Attempt

The complete Critical Incident and Reporting Policy can be found in Connect Family Choice under the Provider Resources Tab

For CBAS Incident Report Form see:
https://www.caloptima.org/en/ForProviders/Long-TermCare/LTCForms

ACCESS STANDARDS FOR ONECARE

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is required to adhere to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). DHCS and CMS implemented these standards to ensure that OneCare members can get an appointment for care on a timely basis, reach the provider over the phone and access interpreter services, as needed.

Contracted physicians and health networks are expected to comply with these appointments, telephone access, practitioner availability and linguistic service standards. OneCare monitors their health networks and providers for compliance. OneCare may develop a corrective action plan for providers and health networks that do not meet these standards. Please refer to CalOptima Health Policy MA.7007: Access and Availability Standards for more information related to CalOptima Health's monitoring process.

UNDERSTANDING THE ACCESS STANDARDS

Please see below for a brief description of the access standards for OneCare members:

Primary Care and Behavioral Health Services Standards:

Type of Care	Standard
Emergency Services	Immediately
Urgent Care Services	Immediately
Services not Emergent or Urgently Needed but Require Medical Attention	Within 7 business days
Routine and Preventive Care	Within 30 business days

Cultural and Linguistic Standards:

Description	Standard
Oral Interpretation	Oral interpretation including, but not limited to, sign language will be made available to members at key points of contact through an interpreter, either in person (upon request) or by telephone, 24 hours a day, 7 days a week.
Written Translation	All written materials to members will be available in all threshold languages as determined by CalOptima Health in accordance with CalOptima Health policies MA.4002: Cultural and Linguistic Services.
Alternative Forms of Communication	Informational and educational information for members in alternative formats will be available at no cost in all threshold languages upon request in at least 20-point font, audio format or braille, or as needed within 21 business days of request or within a timely manner for the format requested.
Telecommunications Device for the Deaf	Teletypewriter (TTY) and auxiliary aids will be available to members with hearing, speech or sight impairments at no cost, 24 hours a day, 7 days a week. The TTY line is **711**.

Description	Standard
Cultural Sensitivity	Practitioners and staff will encourage members to express their spiritual beliefs and cultural practices, be familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrate these beliefs into treatment plans.

Other Access Standards:

Specialist Care	Members shall have access to necessary specialist care, and in particular female members are given the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with a Medicare contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Call OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. Visit us at **www.caloptima.org/OneCare**.

ACCESS STANDARDS FOR CALOPTIMA HEALTH MEDI-CAL MEMBERS

CalOptima Health adheres to patient care access and availability standards as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). DHCS and DMHC implemented these standards to ensure that Medi-Cal beneficiaries can get an appointment for care on a timely basis, reach the provider over the phone and access interpreter services, as needed.

Contracted providers and health networks are expected to comply with these appointments, telephone access, practitioner availability and linguistic service standards. CalOptima Health monitors its health networks and providers for compliance. CalOptima Health may develop corrective action plans for providers and health networks that do not meet these standards. Please refer to CalOptima Health Policy GG.1600: Access and Availability Standards for more information related to CalOptima Health's monitoring process.

UNDERSTANDING THE ACCESS STANDARDS

Please see below for a brief description of the access standards for CalOptima Health Medi-Cal members:

Access to Emergency/Urgent Medical Care:

Type of Care	Standard
Emergency Services	Immediately, 24/7
Urgent Care Services	Within 24 hours of request

Access to Primary Care:

Type of Care	Standard
Urgent Appointments that DO NOT Require Prior Authorization	Within 48 hours of request

Type of Care	Standard
Non-Urgent Primary Care	Within 10 business days of request
Routine Physical Exams and Wellness Visits	Within 30 calendar days of request
Initial Health Appointment (IHA) or Individual Health Education Behavioral Assessment (IHEBA)	Within 120 calendar days of Medi-Cal enrollment

Access to Specialty and Ancillary Care:

Type of Care	Standard
Urgent Appointments that DO NOT Require Prior Authorization	Within 48 hours of request
Urgent Appointments that DO Require Prior Authorization	Within 96 hours of request
Non-Urgent Specialty Care	Within 15 business days of request
Non-Urgent Ancillary Services	Within 15 business days of request

Access to Behavioral Health Care:

Type of Care	Standard
Routine Care with a Mental Health (Non-Physician) Outpatient Services Provider	**Within 10 business days of request**
Follow-up Routine Care with a Mental Health (Non-Physician) Outpatient Services Provider	Members have a follow-up visit with a mental health (non-physician) outpatient services provider within 20 calendar days of initial visit for a specific condition
Follow-up Routine Care with a Mental Health (Physician) Outpatient Services Provider	Members have a follow-up visit with a mental health (physician) outpatient services provider within 30 calendar days of initial visit for a specific condition

Telephone Access Standards:

Description	Standard
Telephone Triage	Telephone triage will be available 24/7. Telephone triage or screening waiting time will not exceed 30 minutes
Telephone Wait Time During Business Hours	A non-recorded voice (primary care provider [PCP] or specialist office) within 30 seconds
Urgent Message During Business Hours	Practitioner returns the call within 30 minutes
Non-Emergency and Non-Urgent Messages During Business Hours	Practitioner returns the call within 24 hours
Telephone Access After/During Business Hours for Emergencies	The phone message and/or live person must instruct members to call 911 or go to the nearest emergency room
After-Hours Access	A PCP or designee will be available 24/7 a week to respond to after-hours member calls or to a hospital emergency room practitioner

Cultural and Linguistic Standards:

Description	Standard
Oral Interpretation	Oral interpretation including, but not limited to, sign language will be made available to members at key points of contact through an interpreter, either in person (upon request) or by telephone, 24/7
Written Translation	All written materials to members will be available in all threshold languages as determined by CalOptima Health in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services

Description	Standard
Alternative Forms of Communication	Informational and educational information for members in alternative formats will be available upon request or standing request at no cost in all threshold languages in at least 20-point font, audio format or braille, or as needed within 21 business days of request or within a timely manner for the format requested
Telecommunications Device for the Deaf	Teletypewriter (TTY) and auxiliary aids shall be available to members with hearing, speech or sight impairments at no cost, 24/7. The TTY Line is **711**
Cultural Sensitivity	Practitioners and staff shall encourage members to express their spiritual beliefs and cultural practices, be familiar with and respectful of various traditional healing systems and beliefs, and, where appropriate, integrate these beliefs into treatment plans

Other Access Standards:

Description	Standard
Physical Accessibility	Members with disabilities shall have access that includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces and drinking water provisions
In-Office Wait Time for Appointments	Less than 45 minutes before being seen by a provider
Rescheduling Appointments	Appointments will be promptly rescheduled in a manner appropriate to the member's health care needs and that ensures continuity of care is consistent with good professional practice
Sensitive Services	A member may self-refer to an out-of-network provider to receive sensitive services without prior authorization
Minor Consent Services	Available to a member under the age of 18 in a confidential manner without parental consent
Family Planning Services	A member may self-refer to any qualified family planning practitioner, including an out-of-network practitioner to receive family planning services

Moral or Ethical Objection: In the event a provider has a moral or ethical objection to providing a covered service to a member, CalOptima Health or a health network shall refer the member to a different provider at no extra cost to CalOptima Health.

CalOptima Health Policies and Procedures:
GG.1118: Family Planning Services, Out-of-Network
GG.1508: Authorization and Processing of Referrals
GG.600: Access and Availability

STANDARDS OF CARE

Members have the right to get covered health services in a timely manner. Below is a list of covered services and standards for providing care to Medi-Cal members.

Covered Services	CalOptima Standards of Care
Emergency Services	Immediately, 24 hours a day, 7 days a week
Urgent Care Services	
Urgent Care Services that do not need Prior Authorization	Within 24 hours
Urgent Care Services that need Prior Authorization	Within 96 hours
Non-Urgent Services	
Acute Care	Within 3 working days
Primary care	Within 10 working days
Routine Physical Exams and Health Assessments	Within 30 calendar days
Specialty Care	Within 15 working days
Ancillary Services	Within 15 working days
Exceptions to Time Frames for Appointments	Appointment time frames can be longer if your provider feels that a longer wait time will not be harmful to your health.
Initial Health Assessment (IHA) or Individual Health Education Behavioral Assessment (IHEBA)	Within 120 calendar days after becoming a CalOptima member
First Prenatal Visit	Within 14 calendar days
Subsequent Prenatal Appointments	All medically necessary services for pregnant members will be covered. Appointments shall be available to a member in accordance with applicable Department of Managed Health Care (DMHC) regulations and the American of College of Obstetricians and Gynecologists (ACOG) standards and guidelines.
Certified Nurse-Midwife and Certified Nurse Practitioner Services	If certified nurse-midwife or practitioner services are not available, you may self-refer to out-of-network services.
Sensitive Services	If sensitive services are not available, you may self-refer to out-of-network services.
Minor Consent Services	Available to any CalOptima member under age 18 without parental consent
Family Planning Services	If family planning services are not available, you may self-refer to out-of-network services.
Behavioral Health Care	

Emergency care for a Condition that is Not Life-Threatening	Within 6 hours
Urgent Care	Within 2 calendar days
Routine Care	Within 10 working days
Health Care Delivery Organization (HDO) Access and Availability	
Access to Health Care Delivery Organization (HDO) (Hospitals and Skilled Nursing Facilities)	Within 15 miles or 30 minutes of your home
Hospital Availability	Ratio of hospital to members is 1:25,000 or less
Skilled Nursing Facility Availability	Ratio of skilled nursing facility to members is 1:2,500 or less
Practitioner Access and Availability	
Total Physician Availability	Ratio of total physician to members is 1:1,200 or less
Non-Physician Practitioner Availability	Ratio or non-physician to members is 1:1,000 or less
PCP Availability	Ratio of PCP or members is 1:2,000 or less
Access to PCP	Within 10 miles or 30 minutes of your home
High Volume Specialist Availability	Ratio of specialist to members is 1:5,000 or less
Access to High Volume Specialist	Within 30 miles or 45 minutes of your home
Telephone Access Business and After hours	Available 24 hours a day, 7 days a week
Telephone Wait Time during Business Hours	Less than 30 seconds
Emergency Message during Business and After Hours	Return call with 5 minutes
Urgent Message during Business Hours	Return call within 30 minutes
Non-emergency and Non-urgent message during Business Hours	Return call within 24 hours
Telephone Triage or Screening Service	Available 24 hours a day, 7 days a week
Telephone Triage or Screening Wait Time	Less than 30 minutes
Interpreter Services	Available 24 hours a day, 7 days a week
Written Materials	Available in English, Spanish, Vietnamese, Farsi and Korean
Telecommunication Device for the Deaf (TDD)	Available upon request at no cost
Rescheduling Appointments	Appointments will be rescheduled to a time that meets your health care needs.

Quality Improvement for Health Services

Quality Improvement and Health Equity

Information about our Quality Improvement and Health Equity program and initiatives

The link below provides information about CalOptima Health's Quality Improvement and Health Equity Program which includes the Quality Improvement (QI) Program Evaluation, the Quality Improvement and Health Equity Transformation Program (QIHETP) and Work Plan, and the Quality Improvement Health Equity Committee (QIHEC) Activities Report.

For information on CalOptima's Quality Improvement and Health Equity please refer to the link below:

https://www.caloptima.org/en/ForProviders/Resources/QualityImprovement

Initial Health Appointment Reference Guide for PCPs

What is the Initial Health Appointment?
The Initial Health Appointment (IHA) is a comprehensive assessment completed during the member's first visit with their selected or assigned primary care provider (PCP). The Department of Health Care Services (DHCS) requires that all newly enrolled members be offered and provided access to an IHA within the first 120 days of their enrollment date. The IHA must be provided in a way that is culturally and linguistically appropriate for the member. For members under the age of 21, the IHA should be offered within 120 days following the date of enrollment or within the most recent Bright Futures periodicity timelines, established by the American Academy of Pediatrics for ages 2 and younger, whichever is less.

Components of a Complete IHA:
The IHA must be completed by the PCP within the primary care medical setting and include the following:

- Comprehensive history, which includes history of present illness, past medical history, social history and review of organ systems
- Assessing and identifying risks, age-appropriate preventive screenings, and referrals to appropriate services
- Comprehensive physical and mental status exam
- The diagnosis, health education and a plan for treatment of any disease

Identifying Members in Need of an IHA
Every month, CalOptima Health provides a list of new members due for IHA to each health network to distribute to the assigned PCP. Providers are required to complete the IHA on each new member.

Codes for Documenting the IHA

- IHA completion is documented using Current Procedural Terminology (CPT) codes, listed in the below table.
- Document support codes to show additional components covered using IHA Visit Supplemental Codes.
- In addition to submitting appropriate codes, make sure to document primary care visits, child and adult preventive services, referrals for screenings and labs in the member file.
- The IHA is a preventive service, paid under current contract.

Tips for Meeting the IHA Requirement:

- Complete the IHA within 120 days of member's effective date with CalOptima Health, and code for all applicable services.
- You may complete and code for the IHA as applicable during a sick visit.
- The IHA can be administered over the course of multiple visits, provided that all components are completed within 120 days.

What Provider Offices Need to Know:

- Use standardized documentation to make it is easier to gather and track information.
- Send in complete and accurate CPT codes.
- **Contact members shown on your monthly new member lists whom you have not yet seen**. Document all outreach attempts to schedule the IHA in the member chart.
- If a member, parent, guardian or case worker submits a request for preventive services, an appointment must be made for a visit to take place within 10 working days.
- Members with unsuccessful IHA completions require a minimum of three documented outreach attempts. Examples could include a phone call, letter or postcard.

Table: IHA Visit Primary Codes

Main CPT Code	Can be pair with ICD-10 Code	Code Description
99202	Z00.00, Z00.01, Z00.8, Z00.121, Z00.129	OFFICE OUTPATIENT NEW 20 MINUTES
99203		OFFICE OUTPATIENT NEW 30 MINUTES
99204		OFFICE OUTPATIENT NEW 45 MINUTES
99205		OFFICE OUTPATIENT NEW 60 MINUTES
99211		OFFICE OUTPATIENT VISIT 5 MINUTES
99212		OFFICE OUTPATIENT VISIT 10 M NUTES
99213		OFFICE OUTPATIENT VISIT 15 M NUTES
99214	Z00.00, Z00.01, Z00.8, Z00.121, Z00.129	OFFICE OUTPATIENT VISIT 25 MINUTES
99215		OFFICE OUTPATIENT VISIT 40 MINUTES
99242		OFFICE CONSULT NEW/EST PT 30 MIN
99243		OFFICE CONSULT NEW/EST PT 40 MIN
99244		OFFICE CONSULTATION NEW/ESTAB PT 60 MIN
99381	Z00.00, Z00.01, Z00.110, Z00.121, Z00.129	INITIAL PREVENTIVE MEDICINE NEW PT <1 YEAR
99382		INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS
99383		INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS
99384		INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR
99385		INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39 YRS
99386		ADULT PREVENTIVE VISIT NEW PT 40-64 YRS
99387		ADULT PREVENTIVE VISIT NEW PT 65+ YRS
99391		PERIODIC PREVENTIVE MED EST PT <1 YR
99392		PERIODIC PREVENTIVE MED EST PT 1-4 YRS
99393		PERIODIC PREVENTIVE MED EST PT 5-11 YRS
99394		PERIODIC PREVENTIVE MED EST PT 12-17 YRS
99395		PERIODIC PREVENTIVE MED EST PT 18-39 YRS
99396		ADULT PREVENTIVE VISIT EST PT 40-64 YRS
99397		ADULT PREVENTIVE VISIT EST PT 65+ YRS
99461		1ST CARE PR DAY NML NB XCPT HOSP/BIRTI DNG CNTR
Z00.00		ENCNTR ADULT MEDICAL EXAM W/O ABNRML FNDGS
Z00.01		ENCNTR ADULT MEDICAL EXAM W/ ABNRML FNDGS
Z00.8		ENCNTR FOR OTHER GENERAL EXAMINATION
Z00.121		ENCNTR, ROUTINE CHILD HEALTH EXAM W/ABNRML FNDGS
Z00.129		ENCNTR, ROUTINE CHILD HEALTH EXAM W/O ABNRML FNDGS
Z00.110		HEALTH EXAM FOR NEWBORN UNDER 8 DAYS OLD
Z1032		INITIAL ANTEPARTUM OFFICE VISIT (SUBJECT TO 20% CUTBACK WHEN BILLED WITH PLACE OF SERVI CE CODE 22 HOSPITAL OUTPATIENT)
Z6500		INITIAL COMPREHENSIVE NUTRITION PSYCHOSOCIAL & HEALTH EDU ASSESMENTS& DEVE LOP CARE PLAN

99304		INITIAL NURSING FACILITY CARE/DAY 25 MINS
99305		INITIAL NURSING FACILITY CARE/DAY 35 MINS
99306		INITIAL NURSING FACILITY CARE/DAY 45 MINS
99341		HOME VISIT NEW PATIENT LOW SEVERITY 20 MINS
99342		HOME VISIT NEW PATIENT MOD SEVERITY 30 MINS
99344		HOME VISIT NEW PATIENT HI SEVERITY 60 MINS
99345		HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN
99347		HOME VISIT EST PT SELF LIMITED/MINOR 15 MINS
99348		HOME VISIT EST PT LOW-MOD SEVERITY 25 MINS
99349		HOME VISIT EST PT MOD-HI SEVERITY 40 MINS

CalOptima Health

Initial Health Appointment Visit Supplemental Codes

Code Type	Code	Code Description
ACEs Screening	G9919	ACEs SCREENING, I DGH RISK
	G9920	ACEs SCREENING, LOWER RISK
Health Assessment Depression	90832	PSYTX PT&/FAMILY 30 MIN
	90837	PSYTX PT&/FAMILY 60 MIN
	90853	GROUP PSYCHOTHERAPY
	96156	HLTH BHV ASSMT/REASSESSMENT
	96164	HLTH BHV IVNTJ GRP 1ST 30
	96165	HLTH BH VIVNTJ GRP EA ADDL
	96167	HLTH BHV IVNTJ FAM 1ST 30
	96168	HLTH BHV IVNTJ FAM EA ADDL
	96170	HLTH BHV IVNTJ FAM WO PT 1ST
	96171	HLTH BHV IVNTJ FAM W/O PT EA
	G8431	POS CLIN DEPRES SCRN F/U
	G8510	PT INGELIG NEG SCRN DEPRES
	H2000	COMPREHENSIVE MULTIDISCIPLINARY EVAL
Behavioral Assessment	69127	BRIEF EMOTIONAL/BERAVIORAL ASSESSMENT
Vision and Hearing	92551	OFFICE OUTPATIENT NEW 20 MINUTES
	92552	OFFICE OUTPATIENT NEW 30 MINUTES
	NOTE: Vision screening for children can also be billed with preventive codes (99381- 99385 and 99391- 99395)	
Developmental Autism	96110	DEVELOPMENTAL SCREEN
	96112	DEVEL TST PHYS/QHP 1ST HR
	96113	DEVEL TST PHYS/QHP EA ADD
Substance Abuse	80305	DRUG TEST PRSMV DIR OPT 0
	80306	DRUG TEST PRSMV INSTRMNT
	80307	DRUG TEST PRSMV CHEM ANLY
	99406	TOBACCO USE CESSATION INTERMEDIATE 3- 10 MINS
	99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES
	G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES
	H0049	ALCOHOL AND/OR DRUG SCREENING
	H0059	ALCOHOL AND/OR DRUG SRVCS, BRIEF INTERVENTION, PER 15 MINS
	NOTE: Tobacco use counseling can also be billed with preventive codes (99381- 99387 and 99391- 99397)	
CPSP (Perinatal)	Z6200	INITIAL NUTRITIONAL ASSESSMENT/DEVELOPMENT; 30 MINS
	Z6202	SUBSEQUENT NUTRITIONAL ASSESSMENT/DEVELOPMENT; EA SUB SEQUENT 15 MIN
	Z6300	INIT PSYCHOSOCIAL ASSESS/DEVEL FIRST 30 MIN
	Z6400	NEW CLIENT ORIENTATION EA 15 MIN
	Z6402	INITIAL HEALTH ED ASSESS/DEVE LOP 30 MIN
	Z6404	SUB HEALTH ED ASSESS/DEVELOP 15 MIN

CalOptima Policy and Procedures

CalOptima Health Policies & Procedures

Information on CalOptima's online policy and procedure database, hosted by Compliance 360 can be referenced from the following link:

https://www.caloptima.org/en/ForProviders/Resources/ManualsPoliciesandGuides

CALOPTIMA'S CULTURAL & LINGUISTIC (C&L) SERVICES
Minimum Requirements

I. Interpreter Services for Limited English Proficient (LEP) and Sensory Impaired Members

CalOptima and its contracted health networks shall provide 24-hour access to interpreter services at key points of contact (medical and non-medical). Upon request, CalOptima and its health networks shall provide face-to-face interpreter services, including American Sign Language, and shall ensure documentation of requests for or refusal of language services. CalOptima and its contracted health networks shall make the best effort to have a diverse work force representative of the population served and shall document staff and provider language capabilities for appropriate referral when requested.

II. Informing Members of the Availability of Interpreter Services

CalOptima and its contracted health networks shall inform members of their right to free interpreter services, and its availability. CalOptima and its contracted health networks shall not require or suggest the use of family members, friends (and particularly minors) as interpreters.

III. Providers and Staff Training on Interpreter Service Policies and Procedures

CalOptima and its contracted health networks shall have policies and procedures that describe how to access interpreter services. CalOptima and its contracted health networks shall conduct ongoing education and training to ensure providers' and staff knowledge of interpreter service policies and procedures is current. Education and training shall be conducted at least annually.

IV. Written Member Materials in Threshold Languages and Alternative Formats

CalOptima and its contracted health networks shall provide translation of member materials in CalOptima's identified threshold languages, which include, but are not limited to: member handbooks, newsletters, welcome letter, Notice of Action, form letters such as those related to grievances, and health education materials. For non-threshold languages, CalOptima and its contracted health networks shall provide an oral translation of the written materials using bilingual staff or contracted interpreter service vendors. For members with specials needs, CalOptima and its health networks shall provide member materials in alternative formats (braille, large-size print, PDF and audio) upon request.

V. Cultural Competency Training

CalOptima and its contracted health networks shall have an annual cultural competency training plan which includes, but is not limited to, cultural sensitivity and communication with members of different cultures to ensure that new and current providers and staff are trained on the most updated C&L issues.

VI. Member Complaint Monitoring

CalOptima and its contracted health networks shall monitor member complaints specific to cultural and linguistic barriers.

Cultural Competency Training

Culturally competent care

Learn how to identify members with potential cultural or language needs and when alternative communication methods may be needed. Required for all health care providers and staff who care for CalOptima members in any of its benefit plans.

For CalOptima Cultural Competency Training please refer to the link below:

https://www.caloptima.org/en/ForProviders/ProviderTrainings/CulturalCompetencyTraining

CalOptima Program and Initiative

California Advancing and Innovating Medi-Cal (CalAIM)

What is CalAIM?

CalAIM is a five-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of the Medi-Cal population by meeting people where they are in life, addressing social drivers of health and breaking down barriers in accessing care. CalAIM offers Medi-Cal members coordinated and equitable access to services that address their physical, behavioral, developmental, dental and long-term care needs. CalAIM is a population health approach that prioritizes prevention and whole-person care. It extends services and supports beyond hospitals and health care settings directly into California communities
The initiative leverages Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, including individuals experiencing homelessness, children with complex medical conditions, justice-involved populations with significant clinical needs and the aging population.

CalAIM has three primary goals:

1. Identify and manage member risk and needs through whole-person care approaches and address social determinants of health

2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility

3. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform

Information on CalAIM can be referenced from the following link: https://www.caloptima.org/en/About/

CurrentInitiatives/CalAIM.aspx

OneCare (HMO D-SNP)

What is it?

OneCare (HMO D-SNP) is a Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare means total care. All your Medicare and Medi-Cal benefits are covered in one single plan making it easier to get the health care you need. With OneCare from CalOptima Health, you can choose from more than 1,500 doctors and specialists in Orange County who are ready to serve you.

There are no monthly premiums, and no deductible. We provide prescriptions, vision coverage, and many other benefits. We offer unlimited transportation to and from your medical appointments.
To qualify for OneCare

You must:

- Live in Orange County
- Have Medicare Parts A, B and D
- Have full Medi-Cal with no Share of Cost
- Be age 21 or older

Information on OneCare can be referenced from the following link:

https://www.caloptima.org/en/ForMembers/OneCare

Whole-Child Model

In light of the COVID-19 public health emergency, the Department of Health Care Services (DHCS) has issued temporary guidance and direction for the administration of the Whole-Child Model (WCM) program and California Children's Services (CCS). The guidance ensures that WCM members (CalOptima Health members who are CCS-eligible) can access medically necessary services without any delay.

CalOptima Health is committed to keeping our stakeholders informed and providing opportunities for feedback. Our most recent efforts for the Whole-Child Model (WCM) include:
WCM Program Launch

The Whole-Child Model is live! As of July 1, 2019, CalOptima Health members who are California Children's Services (CCS) -eligible will receive their CCS services and non-CCS services under CalOptima Health's Whole-Child Model program. This means these members will be receiving the majority of their health care needs through CalOptima Health from now on.

Under the WCM program, CalOptima Health members will have the ability to be more involved with their care and have access to additional resources to help navigate the health system. A Personal Care Coordinator (PCC) is assigned to every CalOptima Health WCM member and may be reached for questions regarding their health care.

About the Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. Prior to July 1, 2019, CCS services were carved out (separated) from most Medi-Cal managed care plans, including CalOptima Health.

The Orange County Health Care Agency (OC HCA) managed the local CCS program. It provided case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.

CCS became a Medi-Cal managed care plan benefit in select California counties starting July of 2018. The goal is to improve health care coordination for the whole child, rather than handle CCS conditions separately. **This approach is known as the Whole-Child Model**.

As of July 1, 2019, CalOptima Health members' needs related to CCS services became a part of CalOptima Health's Medi-Cal plan. Under this model, OC HCA will continue to determine eligibility and manage the Medical Therapy Program.

CalOptima Health and OC HCA continue to work diligently on a seamless transition for the CalOptima Health children and families involved.

Information on Whole-Child Model can be referenced from the following link:

https://www.caloptima.org/en/About/CurrentInitiatives/WholeChildModel

Special Needs Plan (SNP) Model of Care (MOC)

Target Population

OneCare is a Medicare Advantage Prescription Drug plan which operates exclusively as a “Zero Cost Share, Medicaid Subset Dual Special Needs Plan.” OneCare members qualify for Medicare by age (turning 65) or by disability (24 months of SSDI, ESRD, or ALS.) Nearly one third of OneCare members are under 65. OneCare members qualify for Medicaid by standards established by the State of California, which include a review of income, assets and in some cases, medical condition. As of March 2011, OneCare had 11,481 members of which 55% were female and 45% were male. The threshold languages spoken by the majority of OneCare members are English, Spanish and Vietnamese. OneCare members represent over twenty ethnic groups with the majority of members being White, Asian/Pacific Islander, Alaskan native, American Indian, Black and Hispanic.

Provider Network

The OneCare provider network is comprised of providers with extensive experience in caring for Medicare and Medicaid populations; the majority of providers participate in CalOptima’s Medicaid program and are experienced with the needs of a dual-eligible population. They also have expertise in care of the frail elderly, those with complex medical conditions such as ESRD, behavioral and substance use and persons with disabilities. The facilities and providers in the OneCare network include primary care providers (PCPs), specialty care providers, nursing staff, allied health providers, mental/behavioral health providers, pharmacies, and laboratories. OneCare has an integrated system of communication that allows communication between the interdisciplinary care team (ICT), the member, the plan, the physician group and the PCP.

Care Management and Coordination

OneCare utilizes a plan-developed health risk assessment (HRA) tool to conduct an initial (within 90 days of enrollment) and annual assessment of OneCare members. The plan uses the HRA questions to assess the health and social risks of each member by assessing responses to health status, hospital and ER utilization, number of medications, ESRD on dialysis, chronic and severe medical conditions and more. The medical management system automatically scores the HRA and groups the members into high, moderate, and low risk levels based on a risk algorithm. The OneCare Clinical Team then reviews and analyzes the report on a daily basis; this team consists of the medical director, director of case management, clinical manager, director of medical data management, director of pharmacy, social worker, manager of performance measurement and the case manager. The PCP reviews and discusses the HRA with the member during the initial and annual visits. A PCP or case manager develops the individualized care plan (ICP) in collaboration with the member, caregiver, or authorized representative in person, or by written or telephonic communication. The ICP components include prioritized goals, barriers to meeting goals, self-management plan, time frame for reevaluation & assessment.

Community Based-Adult Services

About Community-Based Adult Services

Adult day health care

Community-Based Adult Services or CBAS offers assistance and services to low income, elderly or disabled individuals. Participating seniors and disabled individuals receive services at a local community adult day care center, allowing participants to continue living at home, with the intention to minimize the need for placement in nursing homes.

Eligibility guidelines

In addition to being a CalOptima member, to be eligible for CBAS participants must:

- Be 18 years old or older
- Have a physical, behavioral or memory problem
- Need to live in a long-term care facility if you do not get CBAS services

Benefits of program

CBAS participants receive the following benefits:

- Nursing services — to observe and monitor your health and medicines, and supervise your personal care
- Personal care/social services — to help you with hygiene and other daily tasks
- Physical therapy, speech therapy and occupational therapy
- Meal service — to serve you at least one meal per day at the center
- Transportation — to and from the CBAS center, as necessary

Information on Community-Based Adult Services can be referenced from the following link:

https://www.caloptima.org/en/ForProviders/Long-TermCare/AboutCBAS

Dementia Care Aware Cognitive Health Assessment Training

Information on Dementia Care Aware Cognitive Health Assessment Training can be referenced from the following link:

https://www.dementiacareaware.org/education-and-training/

Disability Training

For CalOptima Disability Awareness Training please refer to the link below: https://caloptima.org/ar-EG/ForProviders/ProviderTrainings/DisabilityAwareness

Seniors and People with Disabilities (SPD) training

To help seniors and persons with disabilities (SPD).

Information on Seniors and People with Disabilities (SPD) training can be referenced from the following link:

https://www.caloptima.org/en/ForProviders/ProviderTrainings/SeniorsandPersonswithDisabilities

Long- Term Support Services (LTSS)

Information on Long-Term Support Services can be referenced from the following link:

https://www.caloptima.org/en/ForProviders/Long-TermCare

Behavioral Health Provider FAQs

The administration of outpatient behavioral health services is directly managed by CalOptima Health.

1. Do CalOptima Health behavioral health services require a prior authorization before starting treatment?

Most CalOptima Health behavioral health services are open access and do not require prior authorization, including outpatient medication and therapy services. For services that require prior authorization, please refer here

- CalOptima Health Medi-Cal members seeking behavioral health services can call the CalOptima Health Behavioral Health Line at **855-877-3885** or visit www.caloptima.org to find a behavioral health provider.
- Once the member is in treatment, providers are responsible to ensure the member is at the appropriate level of care. Treatment requires that it be **medically necessary** and provider documentation for each member should clearly support that.

2. Is there a limit to the number of outpatient behavioral health therapy sessions allowed?

Members must present with mild-to-moderate impairments in daily functioning due to a mental health condition. Treatment requires that it be medically necessary and provider documents clinically support the frequency of visits. Providers may be subject to periodic audits to ensure the quality of services and appropriate level of care.

3. What is the credentialing requirement?

Providers must maintain credentialing status with CalOptima Health every three years.

4. How does a provider make a referral for a higher level of care?

The provider can call the CalOptima Health Behavioral Health Line at **855-877-3885** with the member for assistance with coordinating care and linking to the appropriate level of care.

CalOptima Health provides behavioral health services to members who have mild-to-moderate impairments (non-specialty mental health services) due to a mental health condition. The Orange County Health Care Agency (HCA) provides behavioral health services to members who have severe impairments (specialty mental health services).

5. How does a provider refer a member to the HCA Drug Medi-Cal Organized Delivery System (DMC-ODS) for substance use disorder services?

Providers can call with the member on the phone or members can directly call OC Links at 855-OC-Links (855-625-4657) or the OC Beneficiary Access Line (BAL)/Administrative Services Organization (ASO) at 800-723-8641.

- OC Links is a county-operated information and referral line that provides support to anyone in the community seeking behavioral health services or substance use services through HCA. Services are offered via telephone or online at ochealthinfo.com/oclinks.
- ASO provides access to mental health services and Drug Medi-Cal Services for Orange County Medi-Cal beneficiaries. These services include a 24-hour access line and referral to outpatient mental health providers.

6. Where do I submit claims?

Claims should be sent to CalOptima Health.

Electronic Claims Submission	**Paper Claims Submission**
Office Ally	CalOptima Direct Claims
866-575-4120 or www.officeally.com	P.O. Box 11037
Payer ID: "CALOP"	Orange, CA 92856

7. Whom do I contact for additional questions?

You may contact your CalOptima Health Provider Relations representative for further assistance.

- Email: providerservicesinbox@caloptima.org
- Phone: **714-246-8600**

Doula Services

Did you know that doula support services are a Medi-Cal benefit covered at no cost? Doulas can provide support to make the birth and postpartum experiences better.

What are doula services?
Doula services are non-medical support services provided by trained professionals to pregnant persons before, during and after childbirth, including support during miscarriage, stillbirth and abortion. These services may include emotional support, physical comfort measures, and help with communication and decision-making.

Who is eligible for doula services under Medi-Cal?
Pregnant persons or persons who delivered a baby in the last 12 months and are enrolled in Medi-Cal through CalOptima Health.

How can a CalOptima Health member request doula services?
Please contact your provider to request doula support services. You can then contact your health network to find a doula provider.

How can a CalOptima Health member find a doula?
Please call the customer service phone number on the back of your health network card to find enrolled doulas.

I am a doula. How do I provide services to CalOptima Health Members?
For more information on enrolling to provide doula services, please visit our provider page.

How can CalOptima Health members get more information about doula services?
If you have any questions, call CalOptima Health Customer Service toll-free at **1-888-587-8088** (TTY **711**), Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language.

Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age

Early and Periodic Screening, Diagnostic, & Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need and diagnosis; treatment services are provided to correct or ameliorate defects and chronic conditions. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additionally medically necessary services.

In accordance with the requirements in Section 1905(r) of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Section 441.50 et seq., the Department of Health Care Services (DHCS) is responsible for providing full-scope Medi-Cal beneficiaries under the age of 21 with a comprehensive, high-quality array of preventive (such as screening), diagnostic, and treatment services under EPSDT. These services are covered without cost.

For more information please refer to the link below:

https://www.dhcs.ca.gov/services/Pages/EPSDT-Skilled-Nursing-Services.aspx

Compliance

Fraud, Waste, & Abuse (FWA) and Compliance Training

CalOptima's Fraud, Waste, & Abuse (FWA) and Compliance Training can be referenced from the following link:

https://www.caloptima.org/en/ForProviders/ProviderTrainings/FraudWasteandAbuse

Provider Training Includes:

- Reporting fraud or abuse

  Examples of Health Care Fraud and Abuse Include:

  - Upcoding
  - Services not rendered
  - Excessive units and visits
  - Billing under another provider’s ID # or TIN/NPI
  - Billing HCPCS units with CPT codes
  - Unbundling
  - Non-licensed professionals providing services
  - Double billing
  - Level of care misrepresentation
  - Billing for excessive numbers of patients in one day
  - Misuse of modifiers
  - Lack of medical necessity documented
  - Over- or underutilization
  - Billing for cancellations or no-shows
  - Falsifying clinical notes
  - Forgery

If you are aware of suspected fraud or abuse involving a CalOptima Health member or provider, please report it.

Electronic Visit Verification Requirements (EVV) and Reporting

EVV is a telephone and computer-based solution that electronically verifies in-home service visits. EVV solutions must verify the following six (6) data elements:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

For more information please refer to the link below: https://www.dhcs.ca.gov/provgovpart/pages/

evv.aspx

Policy:	HH.2025
Title:	**Health Network Subdelegation and Subcontracting**
Department:	Office of Compliance
Section:	Delegation Oversight

CEO Approval: /s/ Michael Hunn

Applicable to:
- ☒ Medi-Cal
- ☒ OneCare
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy details the requirements and processes required for Health Network Subdelegation and Subcontracting.

II. POLICY

A. Subdelegation

1. Except as otherwise limited by the CalOptima Health, Health Network Service Agreement or CalOptima Health policies, a Health Network may delegate required administrative functions to a Management Services Organization (MSO), medical group, or Independent Practice Association (IPA).

2. Subdelegation shall not absolve a Health Network of oversight responsibilities, or ultimate obligation and responsibilities, set forth in the CalOptima Health, Health Network Service Agreement.

   a. A Health Network may give a Subdelegated entity the authority to act on behalf of the Health Network, but the Health Network shall retain oversight and accountability for the delegated function.

   b. A Health Network shall not abdicate responsibility for the function performed by a Subdelegated entity according to the requirements of the CalOptima Health, Health Network Service Agreement and those established by CalOptima Health policies and procedures (hereafter, "policies").

3. A Health Network shall obtain CalOptima Health's written approval for Subdelegation in accordance with the terms and conditions of this Policy.

4. A Health Network shall provide CalOptima Health with written evidence of Subdelegation including:

   a. A copy of the written agreement that meets all requirements of the CalOptima Health, Health Network Service Agreement and CalOptima Health policies, and includes the following:

i. The Subdelegated entity shall comply with all applicable regulatory standards, Centers for Medicare & Medicaid Services (CMS) instructions, Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA) instructions;

ii. The Subdelegated entity shall comply with all state and federal confidentiality requirements;

iii. The Subdelegated entity shall grant the CMS, DHCS, the Comptroller General, DHHS Office of Inspector General, or their designees, the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years; and

iv. The Health Network shall have the right to revoke the delegation if the Subdelegated entity fails to perform in a satisfactory manner.

b. A description of the relationship between the Health Network and the Subdelegated entity including the following information:

i. The delegated functions;

ii. The responsibilities of the Health Network and the Subdelegated entity;

iii. The frequency of reporting and reviewing the Subdelegated entity's performance of the delegated functions;

iv. The process by which the Health Network evaluates the Subdelegated entity's performance; and

v. The Health Network's remediation if the Subdelegated entity fails to fulfill its obligations including revocation of the delegation.

c. A description of the Health Network's process by which it evaluated and selected the Subdelegated entity to perform the delegated functions, including the Subdelegated entity's score on a selection tool, if applicable; and

d. A record of the Health Network's ongoing oversight process, as requested by CalOptima Health, including:

i. The Health Network's annual evaluation of whether the Subdelegated entity is performing the delegated functions in accordance with the CalOptima Health, Health Network Service Agreement, CMS, DHCS, DMHC, and NCQA standards;

ii. The Health Network's review of the Subdelegated entity's regular reports; and

iii. Reports and data required to be submitted to CalOptima Health.

5. Upon receipt of written notification from CalOptima Health, and as soon as practical, a Health Network shall terminate any delegation that fails to meet standards established by CalOptima Health, any requirement in the CalOptima Health, Health Network Delegation Agreement, or

CalOptima Health Policy GG.1619: Delegation Oversight, to meet the health care needs of Members.

6. A Health Network shall report to CalOptima Health, in accordance with all requirements established in the CalOptima Health, Health Network Delegation Agreement and in CalOptima Health policies, data and information that includes and encompasses all of the Health Network's membership, including those receiving services from a Subdelegated entity.

7. A Health Network shall audit a Subdelegated entity at least annually.

8. A Health Network shall establish standards and performance requirements for the delegated function and requirements for a Subdelegated entity to meet, or exceed, all requirements of the Health Network in the CalOptima Health, Health Network Service Agreement and in CalOptima Health Policy GG.1619: Delegation Oversight.

9. If a Subdelegated entity fails to meet performance requirements, the Health Network shall place the Subdelegated entity on a Corrective Action Plan (CAP). The CAP shall meet the requirements of CalOptima Health Policy HH.2005: Corrective Action Plan and detail:

    a. The Subdelegated entity's deficiencies;

    b. Root cause analysis;

    c. Specific steps, tasks, and activities to bring the Subdelegated entity into compliance; and

    d. A timeline for completion of corrective action and to achieve compliance with performance requirements.

10. A Health Network shall notify CalOptima Health of any Subdelegated entity providing services to Members that is on a CAP. The Health Network shall provide CalOptima Health with a copy of the CAP, upon request.

B. Subcontracting

1. A Health Network may subcontract for certain functions covered by the CalOptima Health, Health Network Service Agreement, in accordance with CalOptima Health policies.

2. A Health Network shall ensure that a subcontract is in writing and includes all provisions required by the CalOptima Health, Health Network Service Agreement.

3. A Health Network shall inform CalOptima Health of a subcontractor's name and business address within sixty (60) calendar days of execution of subcontract.

4. A Health Network shall include the following in a subcontract that relates to the provision of Covered Services:

    a. The subcontractor shall make all books and records relative to the provision of and reimbursement for items and services furnished by the subcontractor to the Health Network available at all reasonable times for inspection, examination, or copying by CalOptima Health, or duly authorized representatives of the state or federal government;

b. The subcontractor shall maintain such books and records:

   i. In accordance with the general standards applicable to such books and records and any record requirements in the CalOptima Health, Health Network Service Agreement and CalOptima Health Policy HH.2022: Record Retention and Access; and

   ii. At the subcontractor's place of business, or at such other mutually agreeable location in California.

c. The subcontractor shall establish and maintain access to medical and administrative records as set forth in the CalOptima Health, Health Network Service Agreement and in CalOptima Health Policy HH.2022: Record Retention and Access;

d. The subcontractor shall ensure access to premises as set forth in the CalOptima Health, Health Network Service Agreement and in CalOptima Health Policy HH.2022: Record Retention and Access;

e. The subcontractor shall provide Covered Services to Members in the same manner that it provides such services to other patients;

f. The subcontractor shall notify the Health Network of any investigation of a subcontractor's professional conduct or any suspension of, or comment on, a subcontractor's professional licensure, whether temporary, or permanent;

g. The subcontractor shall comply with the Compliance Program, as described in CalOptima Health Policy HH.2014: Compliance Program;

h. The subcontractor shall comply with the CalOptima Health Approved Drug List, as set forth in the CalOptima Health, Health Network Service Agreement and in CalOptima Health policies;

i. The subcontractor shall comply with all applicable laws, regulations, and CMS, DHCS, NCQA, and DMHC instructions;

j. The subcontractor shall comply with all state and federal confidentiality requirements;

k. The subcontractor shall meet all applicable credentialing requirements;

l. The subcontractor shall grant, CMS, DHCS, DHHS, DMHC and the Comptroller General, DHSS Office of Inspector General, or their designees, the right to inspect all pertinent information related to the contract during the contract term and for ten (10) years from the final date of the contract period, and in certain instances described in the regulation, periods in excess of ten (10) years; and

m. The Health Network shall have the right to revoke the subcontract if the subcontractor fails to perform in a satisfactory manner.

III. PROCEDURE

A. A Health Network shall notify the Delegation Oversight Department of any Subdelegation or Subcontracted relationships in writing.

B. The Delegation Oversight and Regulatory Affairs & Compliance Departments' staff shall review requests for approval of delegation submitted by a Health Network.

C. CalOptima Health's review may include:

1. Site visits with the prospective Subdelegated entity;

2. Audits;

3. Interviews of the prospective Subdelegated entity staff;

4. Assessment of the prospective Subdelegated entity obtained from other clients, or patients of the prospective Subdelegated entity;

5. Demonstration of capabilities by the prospective Subdelegated entity;

6. Review of the prospective Subdelegated entity's financial reports, statements, and audits; and

7. Background investigations of the prospective Subdelegated entity and key staff of the prospective Subdelegated entity.

D. Upon completion of the initial review, CalOptima Health may deny or approve Subdelegation with corrective action requirements.

1. CalOptima Health shall notify the delegate of its determination, in writing, within sixty(60) calendar days of the initial review.

2. If CalOptima Health approves Subdelegation with corrective action requirements, CalOptima Health shall detail corrective action requirements in a corrective action plan request provided to the Health Network and the Subdelegated entity in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

a. The Health Network and the Subdelegated entity shall comply with the corrective action requirements within the time frames specified in the CAP.

b. The Health Network and the Subdelegated entity shall document meeting all requirements of any CAP to CalOptima Health.

c. CalOptima Health may perform a focused review of the Subdelegated entity to confirm that the Subdelegated entity met requirements of the CAP.

d. CalOptima Health may require further corrective action or may approve or deny Subdelegation upon review of actions taken by the Subdelegated entity to meet requirements of any CAP.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Policy GG.1619: Delegation Oversight
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.2014: Compliance Program
G. CalOptima Health Policy HH.2022: Record Retention and Access
~~H.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Da**te**	**Meeting**
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Ac**tion**	**Date**	**Policy**	**Policy Title**	**Program(s)**
Effective	08/01/2005	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare
Revised	09/01/2015	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare OneCare Connect
Effective	09/01/2015	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal
Revised	12/01/2016	HH.2025	Health Network Subdelegation and Subcontracting	Medi-Cal OneCare OneCare Connect
Retired	12/01/2016	MA.5004	Health Network Sub-delegation and Sub-contracting	OneCare OneCare Connect
Revised	12/07/2017	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare OneCare Connect
Revised	12/06/2018	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare OneCare Connect
Revised	12/05/2019	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare OneCare Connect
Revised	12/20/2021	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare
Revised	11/01/2023	HH.2025	Health Network Sub-delegation and Sub-contracting	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier, Downstream or Related Entity (FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. 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.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.

Term	Definition
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.
Management Services Organization (MSO)	A healthcare entity providing management and administrative support service on behalf of the delegated medical group.
Member	A beneficiary enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Subdelegation	The process by which First Tier Entity expressly grants, by formal agreement, to a Downstream Entity the authority to carry out one or more functions that would otherwise be required to be performed by the First Tier Entity in order to meet its obligations under the delegation agreement.
Subcontracting	A written agreement entered into by the Contractor with any of the following: 1. A provider of health care services who agrees to furnish Covered Services to Members. 2. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS.

Medical Records Documentation and Coding Tips

In ongoing efforts to ensure we report accurate coding and proper chart documentation as required by the Centers for Medicare and Medicaid Services (CMS); we have created coding tips on various topics to assist the provider community.

For more information, please refer to the link below:

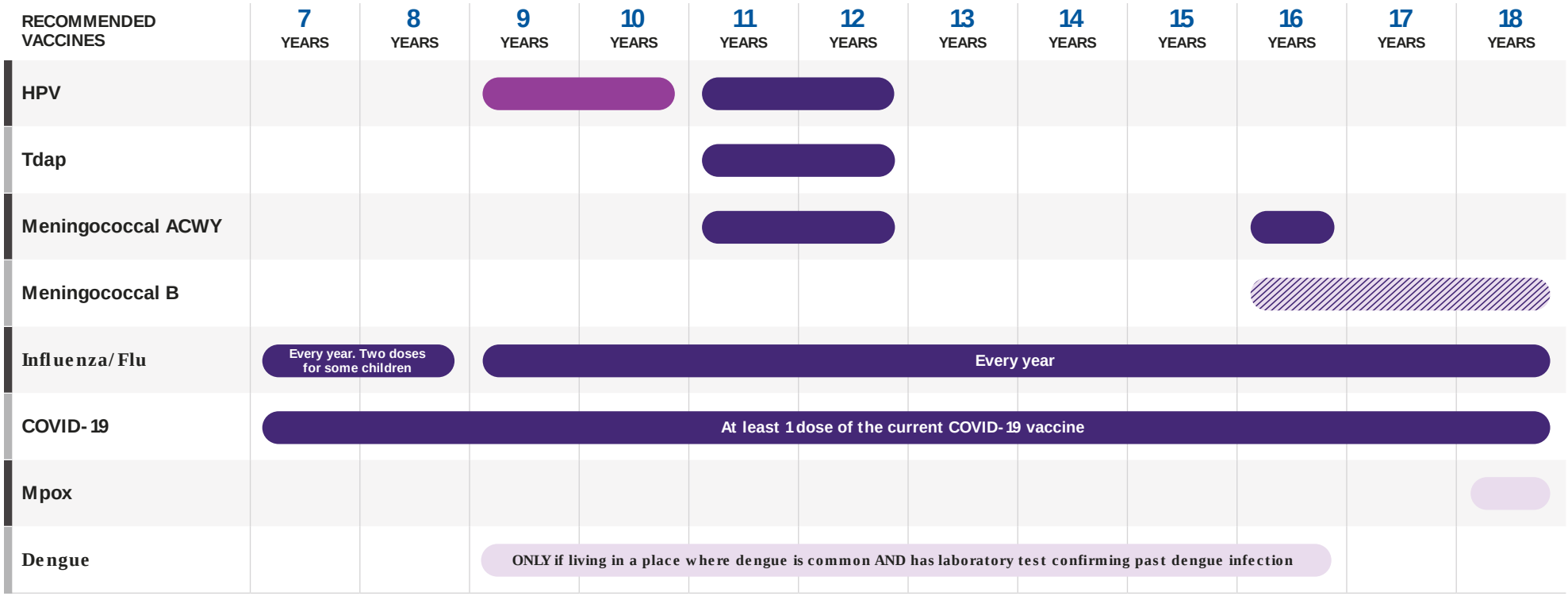
https://www.caloptima.org/en/ForProviders/ProviderTrainings/Coding

Vaccines for Children (VFC)

Older children and teens need vaccines too!

2025 Recommended Immunizations for Children 7–18 Years Old

Want to learn more?
Scan this QR code to find out which vaccines your child might need. Or visit **www2.cdc.gov/vaccines/childquiz/**



KEY

- ALL children in age group should get the vaccine
- ALL children in age group can get the vaccine
- SOME children in age group should get the vaccine
- Parents/caregivers should talk to their health care provider to decide if this vaccine is right for their child

Talk to your child's health care provider for more guidance if:

1. Your child has any medical condition that puts them at higher risk for infection or is pregnant.
2. Your child is traveling outside the United States. Visit **wwwnc.cdc.gov/travel** for more information.
3. Your child misses any vaccine recommended for their age or for babies and young children.

U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

FOR MORE INFORMATION
Call toll-free: **1-800-CDC-INFO (1-800-232-4636)**
Or visit: **www2.cdc.gov/vaccines/childquiz/**

AAFP AMERICAN ACADEMY OF FAMILY PHYSICIANS

American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN®

What diseases do these vaccines protect against?

7-18 YEARS OLD

VACCINE-PREVENTABLE DISEASE	DISEASE COMPLICATIONS	NUMBER OF VACCINE DOSES
HPV (Human papillomavirus) Contagious viral infection spread by close skin-to-skin touching, including during sex	Genital warts and many types of cancers later in life, including cancers of the cervix, vagina, penis, anus, and throat	2 or 3 doses
Tetanus (Lockjaw)* Infection caused by bacterial spores found in soil and dust everywhere; spores enter the body through wounds or broken skin	Seizures, broken bones, difficulty breathing, death	1 dose at age 11-12 years Additional doses if missed childhood doses 1 dose for dirty wounds
Diphtheria* Contagious bacterial infection of the nose, throat, and sometimes lungs; spread through air and direct contact	Swelling of the heart muscle, heart failure, coma, paralysis, death	1 dose at age 11-12 years Additional doses if missed childhood doses
Pertussis (Whooping Cough)* Contagious bacterial infection of the lungs and airway; spread through air and direct contact	Infection of the lungs (pneumonia), death; especially dangerous for babies	1 dose at age 11-12 years Additional doses if missed childhood doses 1 dose every pregnancy
Meningococcal** Contagious bacterial infection of the lining of the brain and spinal cord or the bloodstream; spread through air and direct contact	Loss of arm or leg, deafness, seizures, death	2 doses. Additional doses may be needed depending on medical condition or vaccine used.
Influenza (Flu) Contagious viral infection of the nose, throat, and sometimes lungs; spread through air and direct contact	Infection of the lungs (pneumonia), sinus and ear infections, worsening of underlying heart or lung conditions, death	1 dose each year 2 doses in some children aged 6months through 8 years
COVID-19 Contagious viral infection of the nose, throat, or lungs; may feel like a cold or flu. Spread through air and direct contact	Infection of the lungs (pneumonia); blood clots; liver, heart or kidney damage; long COVID; death	1 or more doses of the current COVID-19 vaccine depending on health status. For more information: **www.cdc.gov/covidschedule**
Mpox Contagious viral infection spread through close, often skin-to-skin contact, including sex; causes a painful rash, fever, headache, tiredness, cough, runny nose, sore throat, swollen lymph nodes	Infected sores, brain swelling, infection of the lungs (pneumonia), eye infection, blindness, death	2 doses
Dengue Viral infection spread by bite from infected mosquito; causes fever, headache, pain behind the eyes, rash, joint pain, body ache, nausea, loss of appetite, feeling tired, abdominal pain	Severe bleeding, seizures, shock, damage to the liver, heart, and lungs, death	3 doses

* **Tdap** protects against tetanus, diphtheria, and pertussis

** **Healthy adolescents:** Meningococcal ACWY vaccine (2 doses); Meningococcal B vaccine (2 doses if needed).

Member Health

Member Health Education

Wellness services are provided in all threshold languages at no cost in-person, telephonically or in a group session.

Please refer to the link below to access the Self-Care Guides below:

- Advance Directives
- Asthma Management
- Cancer
- Health Aging
- Diabetes Management
- Fitness
- High Blood Pressure
- Immunizations
- Injury Prevention
- Medication
- Mental Health
- Nutrition
- Pregnancy/Postpartum
- Tobacco Cessation
- Wellness

https://www.caloptima.org/en/HealthAndWellness.aspx