



A Public Agency

PACE
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PACE Resource Guide



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PACE RESOURCE GUIDE

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This section applies to the following CalOptima programs:

PACE

SECTION 1: INTRODUCTION

We are happy to welcome you as a contracted provider for the Program of All-Inclusive Care for the Elderly (PACE). We appreciate your participation in helping us fulfill our mission to provide access to quality health care delivered in a cost-effective and compassionate manner.

We created this resource guide to help direct you and your staff when working with PACE. We want to ensure that your relationship with us works well for you, your staff and your PACE participants.

Use this guide to assist you with understanding the administrative processes related to providing health care services to PACE participants. PACE's goal is to make this resource guide as helpful as possible. This guide supplements, and does not replace or supersede, the agreement between you and PACE. We will update the resource guide on a periodic basis in accordance with the agreement and in response to changes in operational systems and regulatory requirements. In the event of any discrepancy between the terms of this resource guide and the agreement, the terms of the agreement will govern.

Your satisfaction with PACE is vital to our relationship. We welcome and encourage your comments and suggestions about this resource guide or any other aspect of your relationship with PACE. For clarification, questions or comments about your role as a provider for PACE, please contact the CalOptima Provider Relations department at **714-246-8600**.

HISTORY AND PHILOSOPHY OF PACE

PACE is a unique program for adults over the age of 55 whose health status requires ongoing medical care and supportive services.

During the 1970s, a San Francisco-based program now known as On Lok Lifeways developed an innovative model called Program of All-Inclusive Care for the Elderly (PACE). The PACE model introduced a wide range of medical and social services designed to keep frail seniors in the community and out of institutions. Under a special waiver, Medicaid and Medicare paid On Lok Lifeways a monthly allowance for each participant, and it was On Lok Lifeway's responsibility to arrange and provide individualized medical and social services to best serve each participant.

PACE gained public policy permanency with Medicare provider status in the late 1990s. Federal regulations delineated the requirements under Medicare and Medicaid (Medi-Cal in California) for PACE programs in November 1999 and amended them in October 2002. In late 2001, the Centers for Medicare and Medicaid Services (CMS) approved the first PACE agreement. By November 2003, all PACE demonstration projects had transitioned with CMS approval into permanent PACE provider status.

The CalOptima PACE program is a comprehensive health plan serving frail seniors who live in Orange County. PACE receives fixed payments (capitation) from CMS and the California Department of Health Care Services (DHCS) based on the frailty level of our population. We assume full financial risk for all the care needed by our participants.

PACE grew out of our commitment to meet the medical and social services needs of the frailest participants of our community. PACE offers an important alternative when nursing home care and placement might otherwise be the only option. With PACE-provided medical, social and supportive services, frail seniors receive the

assistance they need to remain within the community, enjoying the comforts of home and family for as long as possible.

PARTICIPANT ELIGIBILITY

To be eligible to participate in PACE, an adult must be:

- 55 years of age or older
- Live in our service area
- Be determined eligible for nursing facility services by the State of California
- Be able to live safely in a community setting with proper support

THE MEDICAL MANAGEMENT APPROACH AT PACE

The PACE medical management approach includes:

- Integration of medical, social and supportive services
- Care management and delivery via an interdisciplinary team consisting of primary care providers, nurse practitioners, nurses, social workers, dietitians and others
- Primary care management of specialty and institutional services
- Continuous monitoring of medical conditions and supervision of health and safety

PACE Program	Addresses	Phone Numbers and Website Addresses
CalOptima PACE General Information	13300 Garden Grove Blvd. Garden Grove, CA 92843	General: 714-468-1100 Claims: 714-246-8885 Authorizations: 714-468-1100 Website: www.caloptima.org TDD Line: 714-468-1063

INTERDISCIPLINARY TEAM CARE PLANNING

Each PACE center has an interdisciplinary team (IDT) of health care professionals who are responsible for assessing and treating each of the participants and ensuring their needs are met. The assessment and documentation process is referred to as the “care planning” process. The IDT must complete the participant’s care plan at enrollment, during the first quarter after enrolling, and every six months thereafter. The participants of the IDT meet with the participant and family member(s) to assess the participant’s needs and create a care plan that works in conjunction with each of the other disciplines. This care plan is integral to the PACE model and is used as a guide for the IDT to manage the participant’s needs.

As a contracted provider for PACE, your input in the participant’s care is important and your referral notes will be documented in the participant’s medical record so that the care plan can be adjusted as necessary. Should you have questions regarding this process, please contact the PACE social worker or center manager at **714-468-1100**.

Medical Care Services	Long-Term Care Services
Physician Services	Transportation
Diagnostic Services	Adult Day Health Care
Hospital Care	Nursing Care
Emergency Services	Social Work
Home Health Services	Physical and Occupational Therapy
Skilled Nursing Facility Care	Speech Therapy
Hospice Services	Nutrition
Prescriptions	Home Care
Durable Medical Equipment	Audiology, Dentistry, Optometry, Podiatry, Custodial Care

This section applies to the following CalOptima programs:

PACE

SECTION 2: PARTICIPANTS

ELIGIBILITY AND VERIFICATION

1. The CalOptima PACE enrollment and intake process includes three primary stages:
 - a. Initial eligibility determination
 - b. Home visit
 - c. PACE interdisciplinary team (IDT) assessment
2. As described in the Introduction, in order to be eligible to participate in CalOptima PACE, a person must :
 - a. Be at least 55 years old
 - b. Live in the defined CalOptima PACE service area
 - c. Be determined eligible for nursing facility services by Title 22 California Code of Regulations, Sections 51334 and 51335
 - d. Be able to live safely at home or in a community setting with proper support
3. Persons enrolled in PACE are referred to as participants. All PACE participants carry a unique identification card with them, which includes their assigned PACE participant number. This number is assigned upon enrollment to maintain the privacy and confidentiality of records and avoid the use of protected personal health information (PHI) as a mechanism for identification.
 - a. To verify a participant's PACE eligibility, please call **714-468-1100**.
4. A Participant's enrollment into CalOptima PACE is effective the first day of the calendar month following the date CalOptima PACE receives a signed signature page of the Enrollment Agreement.

PARTICIPANT BILL OF RIGHTS

CalOptima is committed to providing the highest quality of care that promotes autonomy of the individual participant, and instills a level of cooperation between the participant, the family or caregiver, and the CalOptima PACE providers. In order to provide an environment that promotes privacy and dignity for each participant, as well as achieve the highest quality of care, CalOptima PACE developed a Participant Bill of Rights.

1. The staff at CalOptima PACE makes participants aware of their rights in three formats:
 - a. A separate document that can be used at intake and annually thereafter to remind participants of their rights
 - b. Two sections of the Participant Enrollment Agreement Terms and Conditions, a document which is provided and explained at enrollment
 - c. An addendum to the Enrollment Agreement
2. The participant Bill of Rights will be displayed prominently throughout the CalOptima PACE center and be included in the Participant Enrollment Agreement Terms and Conditions.

RESPECT AND NON-DISCRIMINATION

PACE participants have the right to considerate and respectful care from all CalOptima PACE staff at all times and under all circumstances. Participants have the right not be discriminated against in the delivery of required

PACE services based on race, ethnicity, national origin, religion, sex, sexual orientation, age, mental or physical disability, or source of payment. Specifically, participants have the right to be assured of the following:

- Comprehensive health care in a safe and clean environment and in an accessible manner, and to be protected from hazardous situations.
- Dignity and respect, privacy and confidentiality, and humane care in all aspects of treatment
- An appropriate level of care based on the individual plan of care
- Reasonable access to a telephone to make and receive confidential calls or to have such calls made for participants, if necessary
- Freedom from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the participant's medical symptoms
- Encouragement and assistance to exercise civil and legal rights as a participant, including the Medicare and Medi-Cal appeals process, and the ability to voice grievances
- Qualified PACE personnel who carry out the services for which they are responsible
- Having participants' property treated with respect

INFORMATION DISCLOSURE

Participants have the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions. Specifically, the participant has the right to be informed by the PACE interdisciplinary team (IDT) verbally or in writing of:

- Services available from PACE
- Participant Enrollment Agreement Terms and Conditions, including rights and any fees, fully explained in a manner understood by the participant
- Rights and responsibilities of participants and of the rules and regulations governing participation in PACE, as evidenced by an acknowledgment signed by the participant
- The participant's health and functional status

CHOOSING A PROVIDER

Participants have the right to choose health care providers from within the PACE network, specifically in regard to the following:

- Selecting a primary care provider (PCP) from the PACE-assigned PCPs and medical specialists from within the PACE network
- Requesting that a qualified specialist for women's health services furnish routine or preventive women's health services
- Having access to American Indian Health Services without prior authorization from the IDT
- Having access to sexually transmitted disease (STD) services and confidential HIV counseling and testing without prior authorization by the IDT
- Being able to notify a PACE physician, PACE staff member or social worker when a second medical opinion is desired
- Disenrolling from the PACE program without cause at any time

ACCESS TO EMERGENCY SERVICES

Participants have the right to access emergency health care, HIV and sensitive services when and where the need arises without prior authorization by the IDT.

PARTICIPATION IN TREATMENT DECISIONS

Participants have the right to fully participate in all decisions related to their care. If the participant lacks decision-making capacity, the family member or caregiver will be asked to designate a conservator, who will act as the substitute decision-maker. The participant has the right to:

- Participate in the development and implementation of the plan of care, including knowledge of the services to be provided, frequency of services and treatment objectives.
- Receive an explanation of treatment options in a culturally competent manner, make health care decisions, including the right to refuse treatment, and be informed of the consequences of those decisions. Assistance may be provided through an interpreter, amplification or hearing aids.
- Request a reassessment by the IDT.
- Receive an explanation of advance directives and establish them.
- Receive information about participant's health and functional status from the IDT.
- Receive reasonable advance notice in writing of plans for participant's transfer to another treatment setting and the justification for the transfer.

CONFIDENTIALITY OF HEALTH INFORMATION

CalOptima PACE participants have the right to communicate with their health care providers in confidence and are entitled to having their health information safeguarded as protected health information (PHI). Other participant rights include:

- Reviewing and copying their own medical records and requesting amendments to those records
- Receiving confidential treatment of all information contained in their health record
- Obtaining their written consent for the release of information to persons not otherwise authorized under law to receive it
- Providing written consent that limits the degree of information and the persons to whom the information may be given

GRIEVANCE AND APPEALS

Participants have the right to a fair and efficient process for resolving differences with PACE, including a rigorous system for internal review by the organization and an independent system of external review, specifically, the right to:

- Encouragement and assistance to voice grievances to PACE staff and outside representatives of participant's choice free of any restraint, interference, coercion, discrimination or reprisal by the PACE staff
- The ability to appeal any treatment decision of PACE, its employees or contractors through a process described in the Participant Enrollment Agreement Terms and Conditions

Please refer to Sections 3 and 4 of the PACE Resource Guide for more information about the participant grievance and appeals process.

PARTICIPANT RESPONSIBILITIES

At PACE, we believe that participants and their caregiver(s) play crucial roles in the maintenance of a high quality, satisfying care program. PACE participants are encouraged to establish an open line of communication with those providing care and to be accountable for the responsibilities listed below. Providers should familiarize themselves with the participant responsibilities as well.

PACE participants have the responsibility to:

- Provide necessary and complete information for care, be involved in the development of the individualized plan of care, and pay any applicable monthly fees on time.
- Report to the IDT if they do not clearly understand participant expectations.
- Follow the prescribed treatment and plan of care that has been developed for them, and take prescribed medications as directed.
- Provide accurate information to the medical and other professional staff, following instructions and cooperating with care providers.
- Report unexpected changes in their medical condition to the responsible provider.
- Voice any dissatisfaction with the PACE center to the PACE center director, manager, social worker, or home care coordinator.
- Show consideration of the rights of the other participants and all program personnel.
- Attend the PACE center on the days specific to participant's plan of care, and notify the PACE center if participant is unable to come to the center on appointed days.
- Receive all medical care from their PACE physicians, or specialists, and notify PACE if they become injured.
- Inform a PACE staff member if participant is traveling so that PACE can instruct participant how to receive medical services or emergency care if he or she becomes ill while away.
- Notify PACE within 48 hours or as soon as possible if the participant is away from home and an emergency arises.

CalOptima Policies and Procedures:

PA.2010: Enrollment and Intake

PA.5040: Participant Rights

This section applies to the following CalOptima programs:

PACE

SECTION 3: PARTICIPANT GRIEVANCE PROCESS

PACE participants have the right to a fair and efficient process for resolving differences with PACE, including a rigorous system for internal review by the organization and an independent system of external review, including the right specifically to:

- Encouragement and assistance to voice grievances to PACE staff and outside representatives of participant's choice free of any restraint, interference, coercion, discrimination or reprisal by the PACE staff
- The ability to appeal any treatment decision of PACE, its employees or contractors through a process described in the Participant Enrollment Agreement Terms and Conditions

CalOptima PACE staff share responsibility for participants' care and their satisfaction with the services they receive. PACE established a grievance process to address the participants' concerns or dissatisfactions about services provided.

1. Participants receive written information of the grievance and appeals process at the time of enrollment.
2. CalOptima PACE handles all grievances in a respectful manner and maintains the confidentiality of a participant's grievance at all times throughout and after the grievance process is completed. CalOptima PACE shall only release information pertaining to grievances to authorized individuals.
3. If the participant filing the grievance does not speak English, a bilingual PACE staff member or translation services person will be available to facilitate the process.
4. All materials describing the grievance process are available in the following languages: English, Spanish, Vietnamese, and other languages, as requested.
5. CalOptima PACE shall maintain a toll-free number (**855-752-2584**) for filing grievances and for hearing impaired participants (TDD/TTY: **714-468-1063**).
6. Upon enrollment, annually and upon request, CalOptima PACE shall provide written information about the grievance process to participants and or their representatives including, but not limited to:
 - a. Procedures for filling grievances
 - b. Telephone numbers for the filing of grievances received in person or by telephone:
 - i. PACE center Manager: **714-468-1048**
 - ii. PACE Quality Assurance department: **714-468-1100**
 - iii. Locations where participants may file a written grievance:
 - CalOptima PACE center at which the participant is enrolled; or
 - CalOptima PACE Quality Assurance department
13300 Garden Grove Blvd., Garden Grove, CA 92843
7. PACE staff shall not discriminate against a participant because a grievance was filed and shall continue furnishing the participant with all services at the frequency provided in the current plan of care during

the grievance process.

8. CalOptima PACE expects providers to be familiar with the grievance procedures as established by CalOptima PACE.
9. Any method of transmission of the participant's grievance information from one staff member to another is in the strictest confidence, in adherence with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

HOW PARTICIPANTS MAY FILE GRIEVANCES

1. Participants and or their representative may voice a grievance to a PACE staff member in person, by telephone or in writing to a PACE location.
2. A grievance form will be available from the PACE Quality Assurance department, which may be provided to a participant and or his or her representative with the report form, if requested. In order to access the grievance form, please contact the PACE center at **714-468-1100**, or refer to the PACE section of the CalOptima website at: www.caloptima.org/.
3. Any CalOptima staff person can assist a participant and or his or her representative with filing a grievance in the event that assistance is required.

DOCUMENTATION OF GRIEVANCES

1. A CalOptima staff person will make sure the participant has written information regarding the grievance process and document the grievance on the grievance report form on the day of receipt of the grievance or as soon as possible after occurrence of the events.
2. The CalOptima PACE Quality Assurance department shall ensure documentation of complete details of the grievance so that the grievance may be resolved within 30 days; the participant may take further action if they are unsatisfied with the resolution.
3. In the event that a resolution is not reached within 30 calendar days, the participant and or his or her representative shall receive written notice of the status and estimated completion date of the grievance resolution.
4. The PACE Quality Assurance department shall acknowledge the participant's grievance within five calendar days of receipt of the grievance and shall be responsible for coordinating the investigation, designating the appropriate PACE staff participants to take corrective action(s), and reporting the grievance to the interdisciplinary team (IDT).
5. If the participant feels their grievance involves an imminent and serious threat to their health including, but not limited to, potential loss of life, limb or major bodily function, severe pain, or violation of their participant rights, the PACE Quality Assurance department shall expedite the review process to a decision within 72 hours.
6. Upon PACE's completion of the investigation and reaching a final resolution of the grievance, the participant will receive written notification with a report describing the reason for the grievance, a summary of actions taken to resolve the grievance and options to pursue if the participant is not satisfied with the resolution of the grievance.

GRIEVANCE REVIEW OPTIONS

After the participant completes the grievance process, or participates in the process for at least 30 calendar days, and the participant is dissatisfied with the resolution of the grievance, the participant may pursue other options as described below. If the situation represents a serious health threat, the participant and or his or her representative need not complete the entire grievance process, nor wait 30 calendar days to pursue the options listed below.

1. If the participant is eligible for Medi-Cal only, or Medi-Cal and Medicare, he or she is entitled to pursue the grievance with the California Department of Health Care Services (DHCS) by contacting or writing to:

Ombudsman Unit
Medi-Cal Managed Care Division
Department of Health Care Services
P.O. Box 997413
Mail Station 4412
Sacramento, CA 95899-7413
Telephone: 888-458-8609
TTY: 800-735-2922

2. At any time during the grievance process, whether the grievance is resolved or unresolved, the participant and or his or her representative may request a state hearing from the California Department of Social Services by contacting or writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: 800-952-5253
Facsimile: 916-651-5210 or 916-651-2789
TDD: 800-952-8349

3. Participants must request a state hearing within 90 days from the date of receiving the letter for the resolved grievance. The participant and or his or her representative must speak at the state hearing or have someone else speak on their behalf, such as a relative, friend or an attorney.
4. CalOptima PACE assures that every grievance is handled in a consistent manner and that there is communication among the different individuals who are responsible for reviewing or resolving grievances. In order to ensure all participant concerns are addressed and resolved, PACE will also maintain appropriate documentation, so the information can be utilized in PACE's Quality Assurance program.

HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT GRIEVANCE PROCESS

CalOptima PACE grievance procedures enable participants and their families to express any concerns, grievances or dissatisfactions they may have so that CalOptima PACE may resolve them in a prompt and respectful manner. When appropriate, the provider may assist the participant in filing a grievance.

As a provider for PACE, the provider may become aware of a participant with a problem or complaint about PACE, its policies or providers.

- As a provider, you should have the participant or his or her representative call the CalOptima PACE Quality Assurance department at **714-468-1100**, or provide information on participant grievance procedure and a grievance form.
- The grievance form is in the PACE section of the CalOptima website at: www.caloptima.org/.

PARTICIPANT COMPLAINTS ABOUT PROVIDERS

- A provider may be notified of a complaint filed against them by a participant or his or her representative.
- If a grievance related to services provided by a CalOptima PACE contracted provider arises, the PACE Quality Assurance department shall notify the contracted provider's quality assurance staff.

CalOptima Policies and Procedures:

PA.7001: Grievance Process

This section applies to the following CalOptima programs:

PACE

SECTION 4: PARTICIPANT APPEAL PROCESS

All CalOptima PACE staff share responsibility for the care and satisfaction that participants receive. The appeals process enables the participant and or their representative the opportunity to respond to a decision made by the interdisciplinary team (IDT) regarding a request for a service or payment of a service.

1. At any time the participant wishes to file an appeal, PACE staff is available to assist the participant. If the participant does not speak English, a bilingual staff member or translation services will be available to him or her.
2. Participants will not be discriminated against because they filed an appeal. PACE will continue to provide the participant's plan of care during the appeals process.
3. Confidentiality of the appeal will be maintained at all times throughout and after the appeals process including, but not limited to, transmission of appeal information from one CalOptima PACE staff member to another in adherence to Health Insurance Portability and Accountability Act (HIPAA) regulations; information pertaining to the appeal will only be released to authorized individuals.
4. Participants will receive written information on the appeals process at the time of enrollment, annually thereafter, and whenever the IDT denies, defers, or modifies a request for services or refuses to pay for a service. Information includes, but is not limited to:
 - a. Procedures for filing an appeal, including participant's external appeal rights under Medi-Cal and Medicare.
 - b. Telephone number for the filing of an appeal received in person or by telephone:
PACE center manager: **714-468-1048**
PACE Quality Assurance department: **714-468-1100**
5. A participant and or his or her representative may file a written appeal at the following locations:
 - a. CalOptima PACE center at which the member is enrolled; or
 - b. 13300 Garden Grove Blvd., Garden Grove, CA 92843
6. Contracted providers are accountable for all appeal procedures established by CalOptima PACE, and will be monitored by CalOptima PACE for compliance with this requirement on an annual or as-needed basis.
7. All written materials describing the appeal process are available in the following languages: English, Spanish, Vietnamese and other languages, as requested.
8. CalOptima PACE shall maintain a toll-free number (**855-785-2584**) for the filing of an appeal and for hearing impaired participants (**TDD/TTY: 714-468-1063**).

FILING AN APPEAL

1. The appeal process is available to any participant, his or her representative, or treating provider, who disputes denial of payment, or the denial, deferral, or modification of a service by the primary care provider (PCP), or any member of the IDT who is qualified to make referrals.

2. A participant may file any appeal for denial, deferral, or modification of a service or payment for a service verbally or in writing.

STANDARD AND EXPEDITED APPEALS

1. A participant may file an appeal as standard or expedited, depending on the urgency of the case.
2. A participant may file a standard appeal verbally or in writing with any PACE staff member within 180 calendar days of a denial of service or payment. CalOptima PACE may extend the 180-day limit for good cause by CalOptima PACE.
3. A participant may file an expedited appeal verbally or in writing to CalOptima PACE if the participant or provider believes that the participant's life, health or ability to regain maximum function would be seriously jeopardized without provision of the service in dispute.
4. For participants enrolled in Medi-Cal, CalOptima PACE shall continue to furnish the disputed service if the following conditions are met:
 - a. CalOptima PACE is proposing to reduce or terminate services currently being furnished to the participant; and
 - b. The participant requests continuation of the service with the understanding that he or she may be liable for the cost of the contested service if the determination is not made in his or her favor.
5. Under the circumstances listed above, CalOptima PACE shall not discontinue the disputed service for which an appeal was filed until the appeal process concludes.
6. The PACE Quality Assurance department shall acknowledge a standard appeal in writing within five business days of the initial receipt of appeal by CalOptima PACE.
7. For an expedited appeal, the PACE Quality Assurance department shall inform the participant or representative within one business day by telephone or in person that the request for an expedited appeal was received and explain his or her additional appeal rights, as applicable.
8. CalOptima PACE shall document all appeals expressed, either verbally or in writing, on the day that the appeal is received or as soon as possible after the event or events that precipitated the appeal, in an appeal log.
9. Appeals are documented on the appeals form by the participant, his or her representative, or by a treating provider on behalf of the participant. Complete information is required so the appeal can be resolved in a timely manner. For access to the appeals form, please contact the PACE center at **714-468-1100**, or refer to the PACE section of the CalOptima website at: www.caloptima.org/.
10. In the event of insufficient information, the PACE Quality Assurance department shall take all reasonable steps to contact the participant, and or his or her representative, or other appropriate parties to the appeal to obtain missing information in order to resolve the appeal within the designated time frames for an expedited or standard appeal.
11. All individuals involved with the appeal, including the participant or representatives, shall be given written notice of the appeals process and reasonable opportunity to present evidence or submit relevant facts for review to CalOptima PACE, either verbally or in writing.

12. For a standard appeal, the PACE Quality Assurance department shall inform the participant in writing of the decision to reserve or uphold the decision within 30 calendar days of receipt of an appeal, or more quickly if the participant's health condition requires.
13. For an expedited appeal, CalOptima PACE shall make a decision regarding the appeal as promptly as the participant's health condition requires, but no later than 72 hours after receipt of the request for appeal.
 - a. The PACE Quality Assurance department shall provide the participant and or his or her representative and the Department of Health Care Services (DHCS) with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of appeal.
 - b. In the event that the 72-hour time frame needs to be extended, the PACE program director shall provide justification to DHCS regarding the need for extension. The participant shall be notified, both verbally and in writing, by the PACE Quality Assurance department of the pending status and the reason for the delay with the appeal. CalOptima PACE shall notify the participant of the anticipated date by which the appeal decision shall be determined.

THE DECISION ON THE APPEAL

1. When the decision of an appeal is in favor of a participant, that is, the decision to deny, defer or modify a service or payment of a service is reversed, the following shall apply:
 - a. The PACE Quality Assurance department shall provide a written response to the participant or representative within 30 calendar days of receiving a standard appeal, or sooner if the participant's health condition requires.
 - b. For an expedited appeal, CalOptima PACE shall provide the participant permission to obtain the disputed service or provide the service as quickly as the participant's health condition requires, but no later than 72 hours from the receipt of a request for an expedited appeal.

EXTERNAL REVIEW OPTIONS FOR APPEAL — MEDI-CAL

The Medi-Cal external appeal process option is available to participants enrolled in either Medi-Cal only, or Medicare and Medi-Cal.

If the participant and or representative chooses to appeal using the Medi-Cal external process, the PACE Quality Assurance department shall assist the participant and forward the appeal to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-17-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Facsimile: (916) 651-5210 or (916) 651-2789
TDD: 1-800-952-8349

- CalOptima PACE shall not discontinue services for which an external appeal is filed until the external appeal process concludes.
- If the participant and or his or her representative decides to pursue a state hearing, he or she must request the state hearing within 90 days from the day of the Notice of Action (NOA), in which the participant receives notification of the denial, deferral, or modification of service, or denial of payment for a service.

EXTERNAL REVIEW OPTIONS FOR APPEAL — MEDICARE

The Medicare external appeals process option is available to participants enrolled in either Medicare only, or Medicare and Medi-Cal.

- A Medicare enrollee may choose to appeal CalOptima PACE’s decision using Medicare’s external appeals process.
- Standard appeals are resolved within 30 calendar days after the filing of the appeal; expedited appeals are resolved within 72 hours, with a possible 14 day extension.
- The Medicare appeals entity will notify CalOptima PACE with the results of the review.
- If the decision is not in the participant’s favor, there are further levels of appeal; upon request the PACE Quality Assurance department will assist a participant in further pursuing the appeal.

HOW PROVIDERS MAY ASSIST WITH THE PARTICIPANT APPEALS PROCESS

The provider may assist the participant in requesting an expedited appeal if the provider or participant believes that the participant’s life, health or ability to get well is in danger without the service they want. In order to view the Appeal for Reconsideration of Denial form, providers may refer to the PACE section of the CalOptima website at: www.caloptima.org/

CalOptima Policies and Procedures:

PA.7002: Appeal Process

This section applies to the following CalOptima programs:

PACE

SECTION 5: PROVIDER RIGHTS AND RESPONSIBILITIES

PROVIDER REGISTRATION

CalOptima PACE requires providers and practitioners furnishing services to CalOptima PACE participants to register with CalOptima PACE. CalOptima PACE uses the provider registration process to support accurate and timely adjudication of claims. New providers and practitioners can register for the first time with CalOptima PACE through the Provider section of the CalOptima website at: www.caloptima.org, while existing providers can make changes to their registration information online, by phone or fax.

How to Complete the Initial Registration with CalOptima PACE

New providers and practitioners can register online through the provider section of CalOptima's website. Providers registering online must meet identified conditions or provide the following information:

- Active status with Department of Health Care Services (DHCS)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- State medical license
- Malpractice/liability insurance information (carrier and aggregate amounts)
- DHCS certification license (if applicable)
- Service address and phone number
- Supervising physician name and license number (if applicable for non-physician medical practitioner)

How to Change an Existing Provider's Registration Information

1. Existing providers may change their registration information by:
 - a. Emailing Provider Data Management Services at provideronline@caloptima.org
 - b. Calling **714-246-8468**
 - c. Faxing the provider's new information to **714-246-8448**
2. The types of changes that the provider or practitioner may make to his or her registration information include:
 - a. Terminations
 - b. Additional addresses
 - c. Phone/fax/email updates
 - d. Tax Identification Number (TIN) changes (requires submission of a new W-9)

PROVIDER RESPONSIBILITIES

Participants choose their own primary care provider (PCP) from among the PACE contracted primary care physicians. The PCP acts as the primary care manager to all assigned participants and is part of the interdisciplinary team. The PCP is responsible for conducting a physical during the intake process. The results of this physical, along with the documentation from the rest of the IDT, will determine whether the participant may enroll in PACE and will assist with the development of the plan of care. Most PCP's for participants are retained on staff by CalOptima PACE, although some PCPs may be contracted providers. The vast majority of PACE contracted providers are medical specialists.

The PCP should:

- See each assigned participant at least every three months.
- Attend a weekly IDT meeting to discuss the health status of their participants.
- Coordinate and direct appropriate care for participants by means of initial diagnosis and treatment, obtaining second opinions, as necessary, and consulting with the contracting specialists.
- Follow up on referrals made to the specialists to assess the result of the care, medication regimen and special treatment to ensure continuous care.
- Be available to provide health care services 24 hours a day, 7 days a week.

PACE will assist the PCP as follows:

- Coordinate the necessary specialist visits; make appointments with the specialist and transport the participant to the appointment.
- Discourage inappropriate use of medications through utilization review and the input of our pharmacy consultant.
- Help educate the participant on disease prevention practices and early diagnostic services.
- Assist in the transfer of the participant to another PCP, if necessary, or as requested.

CONTRACTED PROVIDER RESPONSIBILITY FOR CONTINUITY OF CARE

In the event of a contract termination, the provider shall acknowledge responsibility for the continuity of care for PACE participants receiving a course of treatment under the provider's care for an acute condition or serious chronic condition at the time of contract termination. Eligible participants have the right to request that the terminated provider continue to provide, and be compensated for, those services that are covered by PACE.

Eligibility for Continuity of Care

A PACE participant is eligible for continuation of care if they experience an acute condition or serious chronic condition. An acute condition is defined as a medical problem that involves a sudden onset of symptoms due to disease, illness or other medical problem that requires prompt medical attention and that has a limited duration.

A serious chronic condition means a medical condition due to disease, illness or other medical problem or medical disorder that is serious in nature and results in either of the following:

- Persists without full care or worsens over an extended period of time
- Requires on-going treatment to maintain remission or prevent deterioration

Contracted Provider Responsibility

Contracted providers will be responsible for providing continuing care under the following conditions:

- Contracted provider's termination or non-renewal was voluntary.
- Contracted provider agrees in writing to be subject to the same contractual terms and conditions of his or her agreement including, but not limited to, credentialing, hospital privileges, utilization review, peer review and quality assurance requirements.

- Contracted provider agrees in his or her contract to accept the payment rates and payment methodologies outlined in the agreement.
- The extent and duration of the continuation of covered services will be as follows:
 - a. If the requesting participant is undergoing a course of treatment from the provider for an acute condition or serious chronic condition, the provider will furnish services on a timely and appropriate basis for up to 90 days, or a longer period if necessary, for the transfer to another provider, as determined by PACE and in consultation with the terminated provider, consistent with good professional practices.
 - b. This continuity of care will not require PACE to cover services or provide benefits that are not otherwise covered under the terms and conditions of PACE.

Process to Request Continuity of Care

When a provider terminates, PACE sends a letter to participants currently under the care of that provider, giving them the provider's termination date and advises that their care will be transferred to another provider. PACE informs the participant by letter that they may request to continue to see the terminated provider based on continuity of care eligibility criteria, and sends a form to the participant to fill out. If requested by the participant, PACE will arrange for care to continue under existing conditions until course of treatment is over or until a suitable transfer can be made.

PROVIDER RIGHTS AND DISPUTE PROCESS

PACE will make every effort to assist a provider in the resolution of complaints or problems encountered while providing health care to PACE participants. For utilization management and prior authorization issues, please see **Section 8: Utilization Management and Authorization for Services** of the PACE Resource Guide or contact the PACE center at **714-468-1100**. For billing and payment issues, please see **Section 7: Claims Submission and Process** of the PACE Resource Guide or contact the Claims department at **714-246-8885**.

Providers can also contact the PACE director or the quality assurance coordinator at **714-468-1100** who will work with other CalOptima departments, as necessary, to respond to the provider's specific issue and come to a resolution.

Summary of the Dispute Process

If not resolved after attempting to go through the department and staff identified above, providers can report any administrative, operational, contractual, or claims or payment concerns, issues or disputes to CalOptima's Grievance and Appeals Resolution Services (GARS), in writing. Disputes must be filed within 365 calendar days of PACE action, or in the case of inaction, within 365 calendar days after the time for contesting or denying claims that expired. Please submit the provider dispute in writing to the Grievance and Appeals Resolution Services (GARS) department at the following address:

CalOptima
GARS
505 City Parkway West
Orange, CA 92868
714-246-8554

- GARS will acknowledge receipt of the dispute within 15 business days, or two business days, if the dispute is sent electronically.
- If the information provided in the written dispute is not adequate, GARS will request missing or additional information in writing.

- The returned complaint shall clearly identify, in writing, the missing reasonably relevant information or information necessary to determine payer liability.
- The provider may submit an amended dispute within 30 working days of the request for additional information.
- Depending on the issue, the GARS department will contact the appropriate PACE or CalOptima department to facilitate a resolution.
- All provider disputes will be resolved within 45 working days from the date of receipt. Details of the resolution or corrective action plan, including the date implemented, are communicated to the provider in writing.

Implementation of the resolution will adhere to the following time frames:

- Immediately upon decision whenever possible; or
- For issues of payment, if the resolution involves additional payment to the provider, the payment will be made no later than 5 working days from the date of resolution; and
- For all non-payment-related issues, no later than 30 calendar days from the date of determination, except in extenuating circumstances.

When making a complaint, provider should make sure to include the following:

- Provider's name and identification number (i.e., NPI)
- Provider's contact information including address, telephone number and fax number of the provider's contact person
- An explanation of the dispute or issue, including any relevant attachments, documentation and supplemental information
- If the dispute involves a service provided to a PACE participant, please include the participant's name, participant's identification number and date of service.

CalOptima Policies and Procedures:

MA.9006: Provider Complaint Process

This section applies to the following CalOptima programs:

PACE

SECTION 6: QUALITY MANAGEMENT AND CREDENTIALING

QUALITY MANAGEMENT OVERVIEW

CalOptima PACE has a Quality Assurance and Performance Improvement (QAPI) program. The QAPI program enables PACE to measure, assess and improve important aspects of health care delivery and the health care outcomes of our participants.

QUALITY PROGRAM GOALS

The QAPI program at PACE adheres to the principles of the National Committee on Quality Assurance (NCQA). QAPI objectively and systematically monitors and evaluates the quality and appropriateness of participant care quarterly and ad hoc across the entire continuum of care delivered by CalOptima PACE and reports results to the Medical Advisory Committee and the CalOptima Board of Directors. The goals of the review process are to assure high level quality care, and to identify, assess and reduce problems affecting care to an acceptable level.

The QAPI program is reviewed and revised annually. The CalOptima Board of Directors annually reviews results and approves the QAPI program.

QUALITY MANAGEMENT

As part of the QAPI, providers are monitored for:

- Participant access to care and availability of care and services
- Compliance with PACE policies and procedures
- Participant satisfaction with care provided
- Coordination of care by the PCP, medical specialists, mental health providers and community facilities caring for the participant
- Cultural and linguistically appropriateness of care, including availability of bilingual staff and telephonic language assistance services
- Program performance and resource utilization management

By monitoring services and addressing problems as they arise, PACE is able to keep its mission and vision of providing quality, affordable care services for the well-being of the frail elderly and to continually lead the movement to improve care for the elderly.

QUALITY EXPECTATIONS FOR MEDICAL SPECIALISTS

Upon receiving authorization from PACE, the medical specialist will:

- Set specialty appointment within 14 days of the request.
- Communicate findings of the visit to the PCP, including recommendations for further diagnostic procedures or therapy.
- Coordinate lab and X-ray request(s) with the PACE center.
- Maintain medical records consistent with state and federal regulations.
- Comply with PACE QAPI policies and procedures
- Contact PACE to refer to another medical specialist who is out of the PACE panel of providers.
- Provide continuity of care services to PACE participants upon termination of a provider's contract.

QUALITY ASSURANCE PROVISIONS FOR PROVIDERS

In addition to complying with the PACE credentialing requirements detailed in this section, the provider is to cooperate and comply with quality assurance provisions including coordination of care, accessibility standards, office waiting time, participant satisfaction surveys, grievance and appeal activities, and communication regarding unusual incidents.

Upon request, the provider may receive a copy of the PACE QAPI manual. In order to access the QAPI manual, please contact the quality assurance coordinator at **714-468-1100**, or refer to the PACE section of the CalOptima website at: www.caloptima.org/.

CREDENTIALING OVERVIEW

The purpose of the CalOptima credentialing process is to verify that participating physicians and other professionals have the necessary and appropriate credentials to provide their services to participants. Providers who are interested in contracting with PACE may initiate the credentialing process by contacting CalOptima's Provider Relations department at **714-246-8600**. The information listed below informs the provider of the credentialing process.

In conducting the credentialing and recredentialing processes for PACE, CalOptima verifies specific information, including:

- California licensure
- Current professional liability insurance or self-insurance
- The provider's primary admitting facility
- Exclusions, suspensions or ineligibility to participate in any state or federal health care program
- Active Medi-Cal/ Medicare provider identification number
- Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate
- Education and training, including board certification (if the provider states on the application that he or she is board certified)
- Work history
- Status of clinical privileges
- History of professional liability claims
- Licenses of any mid-level providers employed under the provider, as well as verification of liability insurance coverage for the mid-level provider

HOW TO COMPLETE THE INITIAL CREDENTIALING PROCESS

Providers interested in contracting with CalOptima PACE must be credentialed. AppCentral is CalOptima's online system to process credentialing applications electronically. To begin the credentialing application process, please follow the steps below:

1. Call CalOptima's Provider Resource Line at **714-246-8600**, and CalOptima staff will complete an Initial Credentialing Application Information form, and submit the completed form to CalOptima's Credentialing department.
2. CalOptima's Credentialing department will send the provider an emailed invitation to participate in the AppCentral credentialing application process.
3. CalOptima will render a decision within 180 calendar days from the date of signature attestation.

4. If a provider is not able to use AppCentral, CalOptima will send a credentialing application by email or fax. Provider can return the completed application and required documents by fax to **714-481-6474**, or by email to HNpractitioner@caloptima.org.

HOW TO COMPLETE THE RECREDENTIALING PROCESS

1. At the time of recredentialing (every three years after initial approved credentialing date), the provider will receive a recredentialing package from CalOptima. The provider will receive an email from AppCentral with a pre-populated application. The provider will be required to complete identified areas of the application and verify information provided on the application is current. The provider will be instructed to forward the completed application and required documents to an identified CalOptima credentialing coordinators.
2. If a provider is unable to forward the application via email, the completed application and required documents can be faxed to **714-481-6474**.
3. CalOptima will render a decision within 180 calendar days from the date of signature attestation.

For questions regarding the credentialing or recredentialing process, please contact CalOptima's Provider Resource Line at **714-246-8600**.

FACILITY SITE REVIEW, MEDICAL RECORDS REVIEW

CalOptima conducts a full-scope facility site review of the CalOptima PACE center as part of its credentialing and recredentialing process. This includes a facility site review (FSR), medical records review (MRR) and physical accessibility review survey (PARS). The purpose of the FSR, MRR and PARS is to ensure that the CalOptima PACE center meets certain minimum state-required standards for their office sites for maintenance of patient medical records and to ensure physical accessibility for participants with disabilities.

CalOptima conducts a full-scope facility site review during the initial credentialing process and every three years thereafter.

KEY POINTS REGARDING THE FSR, MRR AND PARS

1. The FSR includes an on-site inspection and interviews with office personnel.
2. The MRR uses a survey of 10 randomly selected medical records. The MRR review includes, but is not limited to, a review of format, legal documentation practices, and documentary evidence of the provision of preventive care and coordination of primary care services.
3. The PARS surveys the facility site access for participants with disabilities to parking, the building, elevators, doctor's office, exam rooms and restrooms. The survey will also identify if an exam room has a height-adjustable exam table and accessible weight scale for those with disabilities.
4. CalOptima has minimum standards for maintaining member medical records. The following are some of the required elements for maintaining member medical records. For more information on maintaining member medical records, please refer to CalOptima Policy GG.1603 Medical Records Maintenance.
 - a. Designate an individual responsible for the medical records system.
 - b. Label and file all active records in the system to facilitate retrieval on demand.
 - c. Store active records in a secure area.
 - d. Retain inactive records for five years.

- e. File in the medical record within 48 hours of receipt: lab, X-ray, EEG, EKG, consultation reports, hospital and ED reports.
 - f. Date and sign medical records after each encounter.
 - g. Have a system in place to identify, monitor and follow up on participants who do not keep appointments (no shows).
 - h. Maintain confidentiality of medical records.
5. If CalOptima identifies deficiencies during the full-scope facility site review, CalOptima will give the PACE center a Corrective Action Plan, which includes specific time frames for addressing identified deficiencies. CalOptima will not allow the PACE center with major uncorrected deficiencies to provide care to its participants until the identified deficiencies have been corrected.

For more information about the full-scope facility site review process, please call CalOptima's Provider Resource Line at **714-246-8600**, Monday through Friday, from 8 a.m. to 4 p.m.

CalOptima Policies and Procedures:

GG.1603: Medical Records Maintenance

GG.1608: Full Scope Site Reviews

GG.1608a: Facility Site Review Process

GG.1608b: Medical Records Review Process

GG.1609: Credentialing and Recredentialing

MA.7009: Credentialing and Recredentialing

MA.7011: Full Scope Practitioner Office Site Review

MA.7011b: Medical Records Review Process

This section applies to the following CalOptima programs:

PACE

SECTION 7: CLAIMS SUBMISSION AND PROCESS

CalOptima providers rendering services to PACE participants must submit claims using the current version of the CMS-1500 claim form for professional services or a UB-04 form for facility services. When submitting the claim, please be sure to include all required data elements in order to ensure timely payment. Providers must follow all Medi-Cal and or Medicare rules and regulations for billing.

FORMS

Contracted Fee-For-Service (FFS) providers rendering services to PACE participants must submit claims using a CMS-1500 claim form (outpatient visit). Facilities must use a UB-04 form (both inpatient and outpatient visits) to submit claims.

Copies of both the CMS-1500 and UB-04 forms may be downloaded from the CMS website at: [CMS Forms List](#)

CLAIMS PROCESSING OVERVIEW

CalOptima recognizes that a key component of quality health care is timely and efficient medical claims processing. CalOptima processes medical claims primarily per Medi-Cal and Medicare guidelines, and utilizes key industry standard codes and guidelines to promote timely and efficient processing of paper and electronic claims. Contained below is a summary description of CalOptima's claims processing steps.

Claims Filing Time Frames

PACE follows the Centers for Medicare and Medicaid Services (CMS) and Medi-Cal guidelines for timely filing of claims. Providers should file claims within the applicable time frames.

- Providers have one year from the date of service to submit a claim for covered services.
- The CalOptima Claims department will deny claims not submitted within the appropriate time frame.

Edits/Audits

- CalOptima processes all claims on a first-in, first-out basis.
- All claims are subject to a comprehensive series of checks called “edits” and “audits.” The checks validate all data information to determine if the claim should be paid, contested or denied. Edit/audit checks review:
 - a. Data validity
 - b. Prior authorization requirements
 - c. Recipient eligibility on date of service
 - d. Provider eligibility on date of service
 - e. Procedure/diagnosis, and procedure/modifier compatibility
 - f. Other insurance coverage
 - g. Potential for claim duplication
- CalOptima will provide a clear and accurate explanation of the specific reasons for adjusted, denied or contested claim..

ELECTRONIC CLAIMS SUBMISSION

CalOptima accepts claims in both electronic and hard copy formats. This section provides information about electronic claims submission, including Electronic Data Interchange (EDI) claims, and Long-Term Care (25-1) electronic billing.

CalOptima strongly encourages electronic claims submission. What are the benefits of submitting claims electronically to CalOptima?

- Electronic claims submission is cost-effective.
- Providers receive an electronic confirmation of claim submission (from the clearinghouse).
- Electronic submission promotes effective utilization of staff resources.

HOW TO SUBMIT ELECTRONIC CLAIMS TO CALOPTIMA

EDI Claims

CalOptima has contracts with data clearinghouses to receive EDI claims. There is no cost to the provider for the services provided by these two clearinghouses.

To register and submit electronically, contact one of the vendors listed below:

Emdeon

877-271-0054

www.emdeon.com/

Office Ally

866-575-4120

www.officeally.com/

CalOptima Payer Identification Numbers

Provider should use the following CalOptima payer identification (ID) numbers when sending claims electronically to CalOptima. (Note that Emdeon and Office Ally have their own payer identification number and each vendor processes different types of claims):

- **Emdeon: Payer ID “99250”** — For submission of Long-Term Care claims and Facility claims (UB)
- **Office Ally: Payer ID “CALOP”** — For submission of Professional (CMS 1500), Facility (UB) claims and online PM160 entry
- **Long-Term Care Services — (25-1 Form Electronic Billing)** — CalOptima contracts with Emdeon to provide electronic billing for Long-Term Care claims in accordance with the billing requirements and fields on the 25-1 Form. To register for Long-Term Care (25-1 Form) electronic billing, please contact Emdeon at the phone number referenced above.

GUIDELINES FOR HARD COPY CLAIMS SUBMISSION TO CALOPTIMA

CalOptima accepts claims in both electronic and hard copy formats. This section provides information about hard copy claims submission, including guidelines for how to complete the claim form, important tips and relevant billing addresses.

This section explains the basic billing guidelines required for CalOptima processing of hard copy medical CMS 1500 and UB-04 claim forms. Copies of both the CMS 1500 and UB-04 forms may be downloaded from the CMS website at: [CMS Forms List](#)

Following these guidelines helps ensure that CalOptima can pay a provider's hard copy claim quickly and accurately:

1. Type in Designated Area Only

All claims are scanned, so it is important that providers input data on the claim form only in the designated fields. Be sure the data falls completely within the text space and is properly aligned. This will ensure that claims are scanned accurately and avoid rejections or payment delays.

2. Use Alpha or Numeric Characters Only

Use only alphabetical letters or numbers in data entry fields as appropriate. Only use symbols such as "\$, #, cc, gm" or positive (+) and negative (-) signs when entering information in the Specific Details/Explanation/Remarks or the Reserved for Local Use fields of the claim form.

3. Do Not Use Highlighting Pens

Please do not highlight information. When the form and attachments are scanned on arrival at CalOptima, the highlighted area will show up as a black mark, covering the information highlighted.

4. Follow the Date Format

Enter dates in the six-digit format (MMDDYY) without slashes. Refer to the sections of this guide covering claims form completion for appropriate billing form instructions and for additional date format information.

5. Cover Corrections

Do not strike over errors. Do not use correction fluid. Do not use correction tape.

6. Be Sure to Reference Claim Fields or Procedures on Attachments

Attached documents for medical claim forms and Provider Dispute Resolution forms should clearly reference the claim field number or procedure that requires additional documentation.

- a. The claim field number on the attachment should be legible, underlined or circled in black ballpoint pen. Allow adequate line space between each claim field number description.
- b. Attach undersized documentation to an 8 1/2 x 11-inch sheet of 20-lb. white bond paper with non-glare tape. Cut oversized attachments in half (e.g., Explanation of Medicare Benefits, Medicare Remittance Notice, Remittance Advice), and tape each half to a separate 8 1/2 x 11-inch white sheet of paper; staple attachments in the top right corner of the form.

Note: Do not highlight or use tape to fasten attachments to the claim form. Do not use original claims as attachments since they may not be interpreted as original claims. Carbon copies of documentation are not acceptable.

OTHER IMPORTANT TIPS WHEN SUBMITTING BILLS TO CALOPTIMA

1. Timely Filing

CalOptima has timely filing guidelines, which allow the provider one year from the date of service to submit a claim. CalOptima will deny claims not submitted within the appropriate time frame. The claim may be submitted for reconsideration with documentation showing that the claim was submitted timely (e.g., retro eligibility issue).

2. Paper Claims and Submission

When submitting paper claims to CalOptima, providers should send the original claim form and retain a copy for their records.

3. Submission Standards

Providers should not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.

4. Unacceptable Forms

Carbon copies, photocopies, facsimiles or forms created on laser printers are not acceptable for claims submission and processing.

Point of Service (POS) Printouts

Point of Service (POS) printouts, with Eligibility Verification Confirmation (EVC) numbers, are not required attachments unless the claim is over one year old.

HARD COPY CLAIMS SUBMISSION TO CALOPTIMA

To submit a claim in hard copy format to CalOptima, please mail to:

Original Claims
CalOptima Claims Department
P.O. Box 11037
Orange, CA 92856

CO-PAYMENTS

There are no co-payments or deductibles for PACE participants.

ADJUSTED, DENIED OR CONTESTED CLAIMS

CalOptima will provide a written clear and accurate explanation of the specific reasons for such action for adjusted, denied or contested claims.

POTENTIAL BILLING DISCREPANCIES

Should billing discrepancies occur, CalOptima will try to resolve the discrepancy. We may request a copy of the medical record or supplemental information. We will supply a written clear and accurate explanation detailing the necessity for the request.

INCOMPLETE OR PENDING CLAIMS

Claims that fail an edit, or audit check, will “pend” for review by a claims examiner who will identify the reason for the pended status and examine the scanned image of the claim and attachments (if hard copy received). If the examiner detects input errors, the examiner will correct the error and the claim will continue processing. A physician or other qualified medical profession will review claims requiring medical judgment in accordance with the provisions of the Centers for Medicare and Medicaid Services (CMS), California Code of Regulations (CCR), Title 22 and policies established by the Department of Health Care Services (DHCS).

SERVICES PROVIDED WITHOUT PRIOR AUTHORIZATION

In cases where participants pay out of pocket for non-emergency services without prior authorization, CalOptima will pay such claims at the discretion of the interdisciplinary team (IDT) and or the medical director. If the services are deemed not medically necessary or an alternate in-network provider was available, the social worker will discuss payment responsibility with the participant.

CHECKING THE STATUS OF A CLAIM ONLINE

Providers can view claims or check status on CalOptima Link located on CalOptima's website at: www.caloptima.org. New users will need to register with CalOptima Link. Please follow the instructions for checking the status of a claim or a check.

For more information regarding CalOptima Link, see **Section E1: Verifying Member Eligibility** of the CalOptima Provider Manual.

PROBLEMATIC CLAIMS

Claims for which CalOptima establishes reasonable grounds for suspicion of possible fraud, misrepresentation or unfair billing practices will be forwarded to the PACE medical director, and or other outside agencies for review.

CLAIMS PAYMENTS

CalOptima will pay claims to providers within 45 working days from receipt by CalOptima's Claims department. Claims that successfully pass the processing cycle will be adjudicated per regulatory guidelines and or the specific contracted rate. Providers shall not seek additional payments from Medi-Cal and Medicare, other insurance companies or PACE participants. For payment of non-authorized services in which the participant is deemed responsible, as determined by PACE policies and procedures, PACE staff will speak to the participant and or family regarding payment.

GETTING ANSWERS TO COMPLEX CLAIMS QUESTIONS

For more complex claims questions, contact the Claims Resolution Unit at **714-246-8885**, Monday through Friday, from 8 a.m. to noon and 12:30 to 4 p.m.

For questions regarding the submission of claims, please contact CalOptima's Claims department at **714-246-8885**.

This section applies to the following CalOptima programs:

PACE

SECTION 8: UTILIZATION MANAGEMENT AND AUTHORIZATION FOR SERVICES

CalOptima PACE assures quality of care by establishing overall organizational controls including a process for utilization management and review. The utilization management program at PACE is separate from CalOptima's Utilization Management department because PACE relies on the professional judgment of its staff and primary care providers (PCPs) to make medical care decisions. The interdisciplinary team (IDT) also makes decisions in their respective disciplines. The only exceptions are in instances of out-of-network services or a standing referral to a psychiatrist or psychologist that exceeds six months in duration. Both must be approved by the PACE medical director.

PACE provides comprehensive medical and long-term care services to keep participants safe in the community. PACE participants receive care with few prior authorization requirements. The following procedures must be followed for all routine services provided to CalOptima PACE participants:

- All non-emergency services must be authorized by CalOptima PACE prior to services being rendered.
- Providers who render emergency services must notify CalOptima PACE within 24 hours or on the next business day after that service has been rendered.
- CalOptima PACE will contact the provider by telephone requesting the specific service. A Contract Provider Referral form will be completed at that time and forwarded to the provider.
- The provider will receive a provider referral form at the time of the participant visit.

In order to access the Contract Provider Referral form, please call the PACE center at **714-468-1100**, or refer to the PACE section of the CalOptima website at: www.caloptima.org/.

There are three general areas where authorization may be required for some services:

- Referral to a specialist or diagnostic center
- Services recommended by a specialist or another physician not in concurrence with the participant's PCP
- Services which must be approved by the interdisciplinary team (IDT)

Emergency services, preventive services, sensitive services and confidential services do not require prior authorization by PACE.

The Request for Service Consultation form states the reason for referral and the scope of the requested service and will include a numeric authorization number. A provider is to respond to the referring PACE PCP in writing regarding the professional opinion, recommended treatment plan and anticipated follow-up care. All additional services recommended by a provider, including referrals to other providers, diagnostic tests and treatments must be explicitly authorized by PACE.

INTERDISCIPLINARY TEAM APPROVAL REQUIREMENTS

The interdisciplinary team will consider the services listed below for approval based on the PACE authorization criteria, medical necessity, and or ability for the service to improve the participant's quality of life significantly:

- Home care service

- PACE center attendance
- Rehabilitation services
- Nursing home placement
- Durable medical equipment (DME) and other supplies
- Glasses, hearing aids and dentures
- Nutritional supplements
- Portable meals

SERVICES NOT IN CONCURRENCE WITH PACE PCP

As described above, all additional services recommended by a provider, including referrals to other providers, diagnostic tests and treatments must be specifically authorized by PACE. In most cases, the PCP will authorize the additional service, test or treatment, with the exception of the services listed below, which will be considered by the PACE medical director for approval based on authorization criteria, medical necessity and or ability for the service to improve the participant's quality of life significantly:

- Referral to an out-of-network provider
- Standing referral to a psychiatrist or psychologist that exceeds six months in duration

DOCUMENTING A SERVICE REQUEST

Once the PCP has made the decision to refer a participant to an off-site provider, the PCP or designee will generate a Request for Service Consultation form and a PACE staff person will call the provider's office to arrange the appointment.

The Request for Service Consultation form includes the following:

- PACE address, telephone number and an authorization number (providers rendering services to PACE participants should place the authorization number on a CMS-1500 claim form for professional services)
- Participant's full name, date of birth and participant number
- Appointment time and date
- Who authorized the referral, date of authorization and reason for consultation
- A section for a referral provider's report

The participant or representative will bring the Request for Service Consultation form to the scheduled appointment or fax the form in advance to **714-468-1071**. When services are rendered, the provider will complete the "Referral Provider's Report" section of the Request for Service Consultation form including a professional opinion, recommended treatment plan, anticipated follow-up care, and signing and dating the form. All additional services recommended by the provider must be explicitly authorized by PACE.

The provider's office staff will make a copy of the completed Request for Service Consultation form for the participant's medical record and fax the form to **714-468-1071**.

In order to access the Request for Service Consultation form, please call the PACE center at **714-468-1100**, or refer to the PACE section of the CalOptima website at: www.caloptima.org/.

EXCEPTIONS TO AUTHORIZATION REQUIREMENTS

There are specific categories of care for which no authorization is required. PACE covers both **emergency services** and **urgently needed care** when a participant is temporarily out of the approved service area but still in the United States, Canada, and Mexico.

Emergency Services include inpatient or outpatient services furnished immediately in or outside the service area because of an emergency medical condition. An emergency medical condition is a medical condition that is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of a participant in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Urgently Needed Services are covered services necessary to prevent serious deterioration of the health of a participant, resulting from unforeseen illness, injury, prolonged pain, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the participant returns to the PACE service area.

Sensitive Services are covered services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.

DENIAL, DEFERRAL, OR MODIFICATION OF A SERVICE REQUEST

PACE shall issue a Notice of Action for Service or Payment Request, also referred to as a denial letter, for any authorization situation that results in a decision to deny, defer or modify a service request. The form will provide the reason for denial, deferral or modification and then instructs the participant or the participant's representative to file an appeal if they do not agree with the action. Information regarding the appeals process should accompany the Notice of Action for Service or Payment Request. In order to obtain the Notice of Action for Service or Payment Request form, please refer to the PACE section of the CalOptima website at: www.caloptima.org/. For questions regarding authorizations, please call the PACE Center at **714-468-1100**.

PRESCRIPTION DRUG BENEFITS

Each participant enrolled in CalOptima PACE is entitled to Medicare and Medi-Cal covered services, including prescription drugs. The participant's PCP is responsible for managing the care of the participant, including prescription drugs; the PCP may also review recommendations for drug therapy. PACE will not assume financial responsibility for unauthorized drugs or medications dispensed by another pharmacy except in the case of an emergency. PACE participants do not pay any co-payments or deductibles for covered services, including prescription drug coverage benefits.

DISCHARGE PLANNING

Upon discharge from an inpatient hospital, the PACE PCP or designee coordinates discharge planning with the hospital.

TRANSPORTATION SERVICES

PACE provides or otherwise arranges for transportation to and from the provider's service location. PACE may also provide an escort for the participant.

TRANSLATION SERVICES

As detailed in the Cultural and Linguistic program requirement description in **Section 10: Additional Resources and Information**, PACE shall arrange for translation services when appropriate.

CalOptima Policies and Procedures:

AA.1000: Glossary of Terms

MA.1001: Glossary of Terms

This section applies to the following CalOptima programs:

PACE

SECTION 9: SENSITIVE AND CONFIDENTIAL SERVICES

TESTING

All providers must obtain written consent for confidential HIV testing, except when a treating physician or surgeon recommends the test or it is provided at an alternative test site. Under these circumstances, a physician or surgeon may obtain verbal informed consent from the participant.

Disclosure of Test Results

Provider must obtain consent for disclosure of a participant's HIV test results (California Health and Safety Code, Section 120980). Provider must obtain written authorization from a participant prior to each separate disclosure of an HIV test result. Under the law, a physician or surgeon may disclose a participant's test result to a person reasonably believed to be the spouse, sexual partner or person with whom the participant has shared hypodermic needles, but only if the physician or surgeon provided education and counseling to the participant and attempted to obtain the participant's voluntary consent to notify his or her contacts. The physician or surgeon is prohibited from disclosing any identifying information about the participant during the notification (California Health and Safety Code, Section 121015).

DISCLOSURE OF BILLING INFORMATION

When a participant is tested by someone other than the PCP, the participant may elect to:

- Sign a release of confidential information to send medical records and the bill to PACE.
- Allow billing information to be sent to PACE, but refuse to release medical records.
- Choose complete anonymity and refuse to release any information.

NOTE: A claim submitted without a name to determine eligibility for services will not be paid by PACE.

In accordance with state and federal regulations, PACE participants have open access to Sexually Transmitted Diseases (STD) services and Acquired Immune Deficiency Syndrome (AIDS) services. Therefore, PACE participants may receive such services from their PACE PCP, a non-assigned PCP, a contracted medical specialist or an out-of-network provider, including family planning clinics, community clinics or health department clinics and programs.

SEXUALLY-TRANSMITTED DISEASES (STD)

Providers are responsible for filing all required reports on STD diagnosis and treatment as required by law. Such reporting should be documented in the participant's medical record. Providers are responsible for informing the participant of this reporting activity.

Providers are encouraged to ask the participant to authorize the release of diagnosis and treatment information to the participant's PCP in order to ensure continuity of care. Provider must inform participants of their right to refuse or agree to disclose such information. Medical records must be in accordance with state law and professional practice standards on confidentiality.

HIV/AIDS TESTING

PACE policy is to ensure that participants receive information regarding access to confidential HIV counseling and testing.

Providers should advise any participant who chooses to go to an out-of-network confidential test site to sign a release of information form to allow submission of his or her name on the claim. PACE will not reimburse the provider for a claim submitted without the name to determine eligibility for services.

According to California law, providers must report AIDS cases to the County Public Health Department, Division of Communicable Disease Control and Prevention. AIDS is a reportable condition and does not require consent from the participant. Providers are required to report the names of individuals diagnosed with AIDS.

Providers should be aware of the following laws regarding confidentiality and consent for HIV services:

ACCESS FOR THE DISABLED

All PACE provider facilities should be accessible and useable by individuals with disabilities in accordance with the Americans with Disabilities Act of 1990. Access includes physical, alternative and communication accommodations.

Physical Accommodations

Physical accommodations should include:

- Wheelchair access, ramp
- Water availability/water fountain at wheelchair level
- Elevators with floor selection within reach
- Designated parking spaces
- Accessible bathroom or alternative access to bathroom in the building
- Handrails in the bathrooms
- Hallways and exits must not be locked to impair wheelchair access

CalOptima will evaluate the PACE center for access to the disabled during the facility site reviews.

Alternative Accommodations

Providers in older facilities that are inaccessible should make alternative arrangements for treating disabled participants. If it is not possible to find an alternative, a provider should refer the participant to a provider who can meet the participant's needs.

Communication Accommodations

In addition, providers should make appropriate language and communication accommodations, such as provision of sign language interpretation, telecommunications devices for the deaf (TDD/TTY) and or interpreters.

Detailed Infection Control Standards

PACE providers are to maintain and follow infection control policy and procedures. Providers are responsible for training all staff in universal precautions and hand washing, the use and maintenance of the autoclave, cleanup of blood spills, isolation procedures and disposal of biohazardous waste.

INFECTIOUS DISEASE REPORTING

Each provider office must have an established procedure to meet regulations for reporting of infectious diseases to the local health authority (California Administrative Code, Title 17). Providers may request recommendations on treatment procedures from the local public health department. Using a current version of reportable diseases, providers must perform necessary and required epidemiological follow up and institute preventive measures per the local public health department's instructions.

Reporting Form for Participants

Providers must complete the Confidential Morbidity Report (available from the local public health department) and send it to the local authorities. The date the report was sent should be documented in the participant's medical record.

Confidentiality

Information about participants with reportable infectious diseases will be kept confidential and protected from unauthorized disclosure as required by California law.

Reportable Diseases/Additional Reporting Requirements

When reporting certain infectious diseases, providers must also provide additional specific information regarding hepatitis and STDs:

Hepatitis Report

- Type
- Type-specific laboratory findings
- Source of exposure

Sexually Transmitted Infections Report

- Information as to causative agent
- Syphilis-specific laboratory findings
- Complications of gonorrhea or chlamydia infections

DETAILED MEDICAL RECORDS STANDARDS

All PACE providers are required to have a medical record for each participant and to maintain procedures for storage, filing, retrieval, protection of confidentiality and release of information.

Maintenance

Providers must specify a staff member to maintain medical records in order to assure records are:

- Secured from unauthorized use
- Stored in one central medical records area
- Kept current and accessible for care
- Organized in sections
- Securely fastened
- Filed in a manner that assures the ability to retrieve them, either alphabetically by last name, first, middle, or numerically using a terminal digit, serial or uniquely assigned numbering system

Confidentiality

- While the physical medical record belongs to the provider, the information in the record belongs to the participant and must be protected from unauthorized disclosure.
- The medical records department manager or office manager shall be responsible for maintaining, monitoring and enforcing staff compliance in keeping member information confidential, and in the release of member information when requested by the member, or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, and CalOptima HIPAA privacy policies.
- Federal HIPAA privacy regulations require that participants complete the Authorization for Use or Disclosure of Protected Health Information (PHI) form to authorize CalOptima to use or disclose participants' PHI to another person or organization. In order to view the Authorization for Use or Disclosure of Protected Health Information (PHI) form, please visit the PACE section of the CalOptima website at: www.caloptima.org/.
- Federal HIPAA privacy regulations allow participants the right of access to inspect and obtain a copy of their health information contained in a Designated Record Set by completing the Individual Request for Access to Protected Health Information (PHI) form. However, this right does not apply to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. In order to view the Individual Request for Access to Protected Health Information (PHI) form, please visit the PACE section of the CalOptima website at: www.caloptima.org/.

MEDICAL RECORD CONTENT

Providers must meet the standards for medical record documentation in accordance with the National Committee on Quality Assurance (NCQA) and by the state Medi-Cal Program Regulations (Title 22 of the California Code of Regulations). Each medical record must comply with the standards summarized below.

Patient Identification

- Each page in the record contains the participant's name or ID number.

Personal Biographical Information

- Personal biographical data includes, but is not limited to: name and address, age and birth date, sex, telephone number, emergency contact person and nearest relative (phone numbers for each), plan identification, Medi-Cal number, preferred language, and the request or refusal of language assistance services.

Entries

- All entries in the medical record contain author identification and are made in accordance with acceptable legal or documentation standards.
- The record shall reflect the findings of each visit or encounter including, but not limited to, recording the date of service, chief complaints, follow up from previous visits, tests or therapies ordered, treatment plan and diagnosis or medical impression, any physical, psychosocial, or educational needs identified during the encounter, and abnormal results.

Legibility

- The record shall be in a legible handwritten or a printed format.

Specific Conditions

- There is a distinct and separate problem list that includes all significant illnesses and medical conditions including allergies and adverse reactions. If the participant has no known history of adverse reactions, this is appropriately noted on the problem list.
- A separate medication list is maintained for all current medication. The list includes medication name, strength, dosage, frequency, route, and start or stop dates. Also note discontinued medications on the medication list.
- Documentation of appropriately obtained informed consent form is maintained.

Medical History

- Past medical history is easily identified and includes serious accidents, operations, significant health problems, reactions to drugs, and personal habits such as alcohol, drugs, smoking, sexual activity, and diet.
- History and physical records contain appropriate subjective and objective information pertinent to the participant's presenting complaints.
- Appropriate history of immunization records is maintained.

Preventive Health Services

- Documentation of all clinical preventive services is included in the participant's medical record.

Diagnoses, Treatment and Follow Up

- Laboratory studies and other studies as ordered appropriate.
- Working diagnoses are consistent with findings.
- Treatment plans are consistent with diagnoses.
- Encounter forms or notes have notation when indicated regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
- Unresolved problems from previous visits are addressed in subsequent visits.

CalOptima Policies and Procedures:

GG.1603: Medical Records Maintenance

This section applies to the following CalOptima programs:

PACE

SECTION 10: ADDITIONAL RESOURCES AND INFORMATION

CULTURAL AND LINGUISTICS PROGRAM

Cultural and linguistic competence among health care providers is essential to the care and satisfaction of recipients of health care services. The Cultural and Linguistics (C&L) program is designed to ensure that participants, both with and without English proficiency, have access to quality health care and services that are culturally and linguistically appropriate. Specifically, CalOptima's C&L program will focus on three main areas: participants, staffing and providers, and competency.

Participants

- All PACE participants have the right to interpreter services provided by PACE.
- PACE provides written materials for participants in English, Spanish, and Vietnamese, and other languages, as requested.

Staffing and Providers

- CalOptima PACE attempts to recruit culturally and linguistically appropriate staff to better serve its diverse participant population. When a certain linguistic capacity is needed, but not available among the CalOptima PACE staff, PACE staff may access translation services.
- CalOptima PACE offers participants access to providers who are culturally and linguistically similar to the diverse population that PACE serves.

Competency

- CalOptima PACE offers current staff and providers the opportunity to self-report their C&L competence when they are hired or contracted.
- PACE will provide translation services if a certain linguistic capability is unavailable and needed.
- PACE contracts with professional translators to translate written materials into the preferred and or primary languages of the participants.
- PACE has competent staff proofread translated written materials to ensure accuracy, clarity and reading ease.

HEALTH EDUCATION PROGRAM

- Whenever possible, CalOptima PACE provides appropriate quality health care information and education to its participants in an easily accessible manner, based on individual needs.
- Based on the assessment by the IDT, and upon request from the participant, PACE provides education by:
 - a. Distributing to all participants at enrollment general health education materials focused on topics of interest to a frail, elderly population, such as osteoporosis, arthritis and blood pressure
 - b. Distributing discipline-specific clinical materials, determined by each clinical discipline, as part of the participant's plan of care
 - c. Offering direct evaluation through one-on-one counseling with a participant and or family or caregiver and presenting general group education sessions

- If a provider has a participant who identifies an area where health education would be important, the provider should notify a PACE IDT member. CalOptima PACE is committed to meeting the individual needs of their participants.

TRANSPORTATION SERVICES

- All PACE participants have access to medical transportation which includes the following:
 - a. Transportation provided by PACE or a contracted outside service
 - b. Basic life support (BLS) provided by emergency medical technicians for non-emergency transportation of stable patients
 - c. Advanced life support (ALS) provided for use in response to “9-1-1” requests. Ambulance paramedics provide care.
 - d. Non-ambulatory transportation for participants requiring wheelchair or other assisted transport to medical appointments or other covered services
 - e. Critical care transportation for participants requiring a higher level of care for services not routinely available at the facility to which they were initially admitted

ADVANCE HEALTH CARE DIRECTIVES

- Upon enrollment in CalOptima PACE, the primary care physician (PCP) or social worker verifies whether a participant has signed an advance directive. If the participant does not have an advance health care directive and wishes to complete one, the social worker provides assistance as needed. The advance directive will become part of the participant’s medical record.

EXPERIMENTAL AND INVESTIGATIONAL THERAPIES

- PACE usually does not cover experimental and investigational procedures and therapies. Participants may be considered on a case-by-case basis for such therapies.
- PACE should contact the participant’s PACE PCP for further information regarding PACE coverage for a proposed experimental and or investigational therapy.



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