3.How to get care

Pre-approval (prior authorization)

For some types of care, your PCP or specialist will need to ask CalOptima Health for permission before you get the care. This is called asking for pre-approval or prior authorization. It means CalOptima Health must make sure the care is medically necessary (needed).

Medically necessary services are services that are reasonable and necessary to protect your life, keep you from becoming seriously ill or disabled, or reduce severe pain from a diagnosed disease, illness, or injury. For members under age 21, Medi-Cal services include care that is medically necessary to fix or help relieve a physical or mental illness or condition.

The following services **always** need pre-approval (prior authorization), even if you get them from a provider in the CalOptima Health network:

- Hospitalization, if not an emergency
- Services out of the CalOptima Health service area, if not an emergency or urgent care
- Outpatient surgery
- Long-term care or skilled nursing services at a nursing facility (including adult and pediatric Subacute Care Facilities contracted with the Department of Health Care Services Subacute Care Unit) or intermediate care facilities (including Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), ICF/DD-Nursing (ICF/DD-N))
- Specialized treatments, imaging, testing, and procedures
- Medical transportation services when it is not an emergency

Emergency ambulance services do not require pre-approval (prior authorization).

For standard pre-approval (prior authorization) requests, CalOptima Health must respond to your request as soon as your health condition requires, but no more than five business days from when CalOptima Health gets the information it asked for that it reasonably needs to decide (approve, change, or deny) your request. CalOptima Health

must respond, no more than seven calendar days from when CalOptima Health gets your request.

If a provider or CalOptima Health finds that following the standard time frame could seriously endanger your life or health or ability to attain, maintain, or regain maximum function, CalOptima Health will make a faster expedited pre-approval (prior authorization) decision. CalOptima Health will respond as soon as your health condition requires, but no longer than 72 hours from when CalOptima Health gets your request.

In certain cases, CalOptima Health may need more information to decide (approve, change, or deny) your pre-approval (prior authorization) request. If this happens, CalOptima Health has up to 14 more calendar days to decide. Once CalOptima Health gets the needed information, it must make a decision as soon as your health condition requires, but no later than five business days for standard requests or 72 hours for expedited requests. Your provider can ask for an extension for CalOptima Health to respond to standard requests. You can request an extension for standard **or** expedited requests. Clinical or medical staff such as doctors, nurses, and pharmacists review pre-approval (prior authorization) requests.

CalOptima Health does not influence the reviewers' decision to deny, change, or approve coverage or services in any way. If CalOptima Health does not approve the request, CalOptima Health will send you a Notice of Action (NOA) letter. The NOA will tell you how to file an appeal if you do not agree with the decision.

CalOptima Health will contact you if CalOptima Health needs more information or more time to review your request.

You never need pre-approval (prior authorization) for emergency care, even if it is out of the CalOptima Health network or out of your service area. This includes labor and delivery if you are pregnant. You do not need pre-approval (prior authorization) for certain sensitive care services. To learn more about sensitive care services, read "Sensitive care" later in this chapter.

For questions about pre-approval (prior authorization), call **1-888-587-8088** (TTY **711**).

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you might want a second opinion if you want to make sure your diagnosis is correct, you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan, and it has not worked.

Call Member Services at **1-888-587-8088** (TTY **711**). CalOptima Health is here Monday through Friday from 8 a.m. to 5:30 p.m. The call is free. Visit online at **www.caloptima.org**.

CalOptima Health will pay for a second opinion if you or your in-network provider asks for it, and you get the second opinion from an in-network provider. You do not need pre-approval (prior authorization) from CalOptima Health to get a second opinion from an in-network provider. If you want to get a second opinion, we will refer you to a qualified in-network provider who can give you one.

To ask for a second opinion and get help choosing a provider, call **1-888-587-8088** (TTY **711**). Your in-network provider can also help you get a referral for a second opinion if you want one.

If there is no provider in the CalOptima Health network who can give you a second opinion, CalOptima Health will pay for a second opinion from an out-of-network provider. CalOptima Health will tell you if the provider you choose for a second opinion is approved as fast as your medical condition requires, but no more than five business days from when CalOptima Health gets the information it asked for that it reasonably needs to decide your request, CalOptima Health must respond no more than seven calendar days from when CalOptima Health gets your request.

If you have a chronic, severe, or serious illness, or have an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, CalOptima Health will tell you in writing within 72 hours of getting your request.

If CalOptima Health denies your request for a second opinion, you can file a grievance. To learn more about grievances, read “Complaints” in Chapter 6 of this handbook.

4. Benefits and services

Other Medi-Cal programs and services

Other services you can get through Fee-for-Service (FFS) Medi-Cal or other Medi-Cal programs

CalOptima Health does not cover some services, but you can still get them through FFS Medi-Cal or other Medi-Cal programs. CalOptima Health will coordinate with other programs to make sure you get all medically necessary services, including those covered by another program and not CalOptima Health. This section lists some of these services. To learn more, call **1-888-587-8088** (TTY **711**).

Dental services

Medi-Cal Dental FFS is the same as Medi-Cal FFS for your dental services. Before you get dental services, you must show your Medi-Cal BIC card to the dental provider. Make sure the provider takes Dental FFS and you are not part of a managed care plan that covers dental services.

Medi-Cal covers a broad range of dental services through Medi-Cal Dental including:

- Complete and partial dentures
- Crowns (prefabricated/laboratory)
- Diagnostic and preventive dental services such as examinations, X-rays, and teeth cleanings
- Emergency care for pain control
- Fillings
- Orthodontics for children who qualify
- Root canal treatments (anterior/posterior)
- Scaling and root planing
- Tooth extractions
- Topical fluoride

If you have questions or want to learn more about dental services, call Medi-Cal Dental at 1-800-322-6384 (TTY 1-800-735-2922 or 711). You can also go to the Medi-Cal Dental website at https://www.dental.dhcs.ca.gov.

5.Child and youth well care

Child and youth members under 21 years old can get needed health care services as soon as they are enrolled. This makes sure they get the right preventive, dental, and mental health care, including developmental and specialty services. This chapter explains these services.

Other services you can get through Fee-for-Service (FFS) Medi-Cal or other programs

Dental check-ups

Keep your baby's gums clean by gently wiping the gums with a washcloth every day. At about four to six months, "teething" will begin as the baby's teeth start to come in. You should make an appointment for your child's first dental visit as soon as their first tooth comes in or by their first birthday, whichever comes first.

These Medi-Cal dental services are free services for:

Babies age 0-3

- Baby's first dental visit
- Baby's first dental exam
- Dental exams (every six months, and sometimes more)
- X-rays
- Teeth cleaning (every six months, and sometimes more)
- Fluoride varnish (every six months, and sometimes more)
- Fillings
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Kids age 4-12

- Dental exams (every six months, and sometimes more)
- X-rays
- Fluoride varnish (every six months, and sometimes more)
- Teeth cleaning (every six months, and sometimes more)
- Molar sealants
- Fillings
- Root canals

- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

Youths age 13 -20

- Dental exams (every six months, and sometimes more)
- X-rays
- Fluoride varnish (every six months, and sometimes more)
- Teeth cleaning (every six months, and sometimes more)
- Orthodontics (braces) for those who qualify
- Fillings
- Crowns
- Root canals
- Partial and full dentures
- Scaling and root planing
- Extractions (tooth removal)
- Emergency dental services
- *Sedation (if medically necessary)

* Providers should consider sedation and general anesthesia when they determine and document a reason local anesthesia is not medically appropriate, and the dental treatment is pre-approved or does not need pre-approval (prior authorization).

These are some of the reasons local anesthesia cannot be used and sedation or general anesthesia might be used instead:

- Physical, behavioral, developmental, or emotional condition that blocks the patient from responding to the provider's attempts to perform treatment
- Major restorative or surgical procedures
- Uncooperative child
- Acute infection at an injection site
- Failure of a local anesthetic to control pain

If you have questions or want to learn more about dental services, call the Medi-Cal Dental Customer Service Line at 1-800-322-6384 (TTY 1-800-735-2922 or 711), or go to https://smilecalifornia.org/.

6. Reporting and solving problems

State Hearings

A State Hearing is a meeting with CalOptima Health and a judge from the California Department of Social Services (CDSS). The judge will help to resolve your problem and decide whether CalOptima Health made the correct decision or not. You have the right to ask for a State Hearing if you already asked for an appeal with CalOptima Health and you are still not happy with our decision, or if you did not get a decision on your appeal after 30 days.

You must ask for a State Hearing within 120 days from the date on our Notice of Appeal Resolution (NAR) letter. If we gave you Aid Paid Pending during your appeal and you want it to continue until there is a decision on your State Hearing, you must ask for a State Hearing within 10 days of our NAR letter or before the date we said your services will stop, whichever is later.

If you need help making sure Aid Paid Pending will continue until there is a final decision on your State Hearing, contact CalOptima Health, Monday through Friday from 8 a.m. to 5:30 p.m., by calling **1-888-587-8088**. If you cannot hear or speak well, call **711**. Your authorized representative or provider can ask for a State Hearing for you with your written permission.

Sometimes you can ask for a State Hearing without completing our appeal process.

For example, if CalOptima Health did not notify you correctly or on time about your services, you can request a State Hearing without having to complete our appeal process. This is called Deemed Exhaustion. Here are some examples of Deemed Exhaustion:

- We did not make an Notice of Action (NOA) or NAR letter available to you in your preferred language
- We made a mistake that affects any of your rights
- We did not give you an NOA letter
- We did not give you an NAR letter

- We made a mistake in our NAR letter
- We did not decide your appeal within 30 days
- We decided your case was urgent but did not respond to your appeal within 72 hours

You can ask for a State Hearing in these ways:

- **By phone:** Call CDSS' State Hearings Division at 1-800-743-8525 (TTY 1-800-952-8349 or 711)
- **By mail**: Fill out the form provided with your appeals resolution notice and mail it to:

  California Department of Social Services
  State Hearings Division
  744 P Street, MS 09-17-433
  Sacramento, CA 95814

- **Online:** Request a hearing online at **www.cdss.ca.gov**
- **By email:** Fill out the form that came with your appeals resolution notice and email it to **Scopeofbenefits@dss.ca.gov**
  - Note: If you send it by email, there is a risk that someone other than the State Hearings Division could intercept your email. Consider using a more secure method to send your request.
- **By Fax:** Fill out the form that came with your appeals resolution notice and fax it to the State Hearings Division at 916-309-3487 or toll free at 1-833-281-0903

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call **1-888-587-8088** (TTY **711**).

At the hearing, you will tell the judge why you disagree with CalOptima Health's decision. CalOptima Health will tell the judge how we made our decision. It could take up to 90 days for the judge to decide your case. CalOptima Health must follow what the judge decides.

If you want CDSS to make a fast decision because the time it takes to have a State Hearing would put your life, health, or ability to function fully in danger, you, your authorized representative, or your provider can contact CDSS and ask for an expedited (fast) State Hearing. CDSS must make a decision no later than three business days after it gets your complete case file from CalOptima Health.

7. Rights and responsibilities

As a member of CalOptima Health, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of CalOptima Health.

Notice of Action

CalOptima Health will send you a Notice of Action (NOA) letter any time CalOptima Health denies, delays, terminates, or modifies a request for health care services. If you disagree with CalOptima Health's decision, you can always file an appeal with CalOptima Health. Go to the "Appeals" section in Chapter 6 of this handbook for important information on filing your appeal. When CalOptima Health sends you a NOA it will tell you all the rights you have if you disagree with a decision we made. If you get this notice from anyone other than CalOptima Health or an CalOptima Health subcontractor, contact CalOptima Health right away.

Contents in notices

If CalOptima Health bases denials, delays, modifications, terminations, suspensions, or reductions to your services in whole or in part on medical necessity, your NOA must contain the following:

- A statement of the action CalOptima Health intends to take
- A clear and concise explanation of the reasons for CalOptima Health's decision
- How CalOptima Health decided, including the rules CalOptima Health used
- The medical reasons for the decision. CalOptima Health must clearly state how your condition does not meet the rules or guidelines.
- Information about your right to request free of charge copies of all documents and records relevant to the NOA.

Translations

CalOptima Health is required to fully translate and provide written member information

in common preferred languages, including all grievance and appeals notices.

The fully translated notice must include the medical reason for CalOptima Health's decision to deny, delay, modify, terminate, suspend, or reduce a request for health care services.

If translation in your preferred language is not available, CalOptima Health is required to offer verbal help in your preferred language so that you can understand the information you get.