Creating Health Care Solutions

Effective January 1, 2020

This manual is revised periodically. For the most recent version, please visit the Alliance provider website at: www.ccah-alliance.org/providers or call the Provider Services Department at (800) 700-3874 ext. 5504.
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Section 1
Introduction

Organization of the Provider Manual

The Provider Manual (Manual) describes operational policies and procedures of the Central California Alliance for Health (the Alliance). Topics covered in this Manual include, but are not limited to: member eligibility, authorizations, referrals, covered services, services covered by other agencies, care management, cultural and linguistic services, utilization management, quality assurance and improvement, health assessment and screening, member grievances, billing, coordination of benefits, reporting, credentialing, and dispute resolution.

If further information is needed, or to suggest additions or improvements to the Manual, please call the Provider Relations Representatives in your area.

Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
(831) 430-5500

Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101
Salinas, CA 93901-4419
(831) 755-6000

Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B
Merced, CA 95340-4710
(209) 381-5300

The Manual will be revised annually and/or periodically as needed. Providers will be notified when an updated version is effective and the online version is available on the Alliance provider website. Providers may also request a hard copy version by contacting their Provider Relations Representative.

Accessing Provider Information

Alliance Main Website: www.ccah-alliance.org

Provider Website: www.ccah-alliance.org/Providers.html

The current version of the Manual is always available on the Alliance provider website and is a comprehensive resource for information, resources and tools. You can easily access information in the
Section 1. Introduction

Manual through the Table of Contents. Click on any line item or page number in the table of contents to go directly to the section you need. You may also search the Manual by keyword using CTRL + F.

Additional helpful links found on our provider website include the following:

Provider Directory — Search by specific line of business, specialty, provider name, or city.

Provider News — Access the latest Alliance provider news updates.

Health Education and Disease Management Programs — Learn about Alliance health education and disease management programs and download health education materials.

Cultural and Linguistic Services — Learn about interpreter services and access cultural competency and health literacy tools.

Provider Portal: www.ccah-alliance.org/webaccount.html

Contracted providers may use the Provider Portal to check the eligibility status of Alliance members, verify if a member has other primary health insurance, review a member’s prescription history, and search for claims. Primary care providers (PCPs) are able to view information for their linked members.

To utilize this service, visit the Provider Portal and click on the “Provider Portal Login” button and select “New User.” You will need to provide basic registration information, after which a Provider Web & Electronic Data Interchange (EDI) Specialist will contact you to help you to set up an account.

Form Library: http://www.ccah-alliance.org/formlibrary.html

The Form Library contains a list of forms you may require as an Alliance provider (this information can also be found in Section 19).

Alliance Vision, Mission and Values

Our Vision: To be a recognized leader in creating local health care solutions.

Our Mission: Accessible, quality health care guided by local innovation.

Our Values:

Culture — We strive for a respectful, diverse, professional and fun workplace.

Customer Service — Our customers’ satisfaction is our highest priority.

Excellence — We value and continuously improve quality in our services.

Innovation — We leverage local talent to create solutions.

Integrity — We tell the truth and do what we say we will do.

Partnership — We collaborate with others for strong solutions.

Stewardship — We manage responsibly, and earn the trust of partners and regulators.

We achieve the goals set by our Vision, Mission and Values by improving local provider satisfaction, increasing participation in service delivery, and by continually expanding our provider network.
The Alliance is governed by the Santa Cruz-Monterey-Merced Managed Medical Care Commission (also referred to as “the Commission” or the “Alliance Board”), which is comprised of 21 members representing physicians, clinics, hospitals, allied health providers, service agencies and the public.

Two groups provide advice to the Commission: the Physician Advisory Group (PAG) and the Member Services Advisory Group (MSAG). The Commission meets monthly to review local concerns about health care issues, receive advisory input, and revise policy for the Alliance as appropriate. The Alliance is responsive to local input via our regional governance and we align our operations and policies based on industry best practices.

Overview of Alliance Programs

Medi-Cal

Types of Medi-Cal: Levels of Benefits

Medi-Cal is California’s version of the federal Medicaid program. With a combination of federal and state funding, Medi-Cal provides health care coverage to qualifying residents who make less than a certain percentage of the Federal Poverty Level (FPL). Medi-Cal offers three basic levels of benefits — full scope, limited scope and special programs. There is one additional type of full scope eligibility called Share of Cost (SOC).

Full-Scope Medi-Cal

The majority of Alliance Medi-Cal beneficiaries are eligible for full-scope Medi-Cal, which provides coverage for the full range of Medi-Cal covered services. A person may be eligible for full-scope Medi-Cal with or without a share of cost. However, there are some full-scope aid codes that are under the fee-for-service Medi-Cal system. One such example is the Child Health and Disability Prevention (CHDP) Gateway aid codes.

Limited-Scope or Restricted Medi-Cal

Limited-scope, or restricted Medi-Cal, provides coverage only for a limited set of benefits, primarily emergency, pregnancy and long term care services. There is another set of limited-scope aid codes that cover services relating to treatment for breast or cervical cancer. An individual may be eligible for limited-scope Medi-Cal with or without a share of cost. The Alliance currently covers only a few limited-scope aid-codes — primarily breast and cervical cancer treatment programs. Most other limited-scope aid-codes are under the fee-for-service Medi-Cal program.

Special Programs

Medi-Cal also has aid codes that provide coverage under special programs. These special-program aid codes include tuberculosis services, pregnancy-only services and minor-consent services. Individuals in these aid codes are covered under the fee-for-service Medi-Cal program and not through the Alliance.

Share of Cost

Some Medi-Cal beneficiaries have what is known as a Share of Cost (SOC). A SOC is the amount that the individual or family is required to pay out of pocket for medical expenses before becoming eligible for Medi-Cal during that month. For example, if a person has a SOC of $150, he/she must pay that amount out of
Section 1. Introduction

Pocket on medical expenses before Medi-Cal or the Alliance would be responsible for any services rendered that month that are in excess of the member’s SOC. A SOC is a monthly obligation — it must be met each month in order for the individual to be covered by Medi-Cal that month. SOC Medi-Cal recipients do not become eligible for Alliance Health benefits until they have met their share of cost for that month. Once they meet their SOC, they become administrative members of the Alliance and may receive care from any willing Medi-Cal provider in the Alliance’s service area.

Providers can post monies paid for services toward a member’s SOC either via the California Department of Health Care Services (DHCS) website using the Point of Service (POS) device, or by calling DHCS. SOC amounts should be posted on the date the member paid for the service. For assistance with posting a member’s SOC, please contact the Medi-Cal POS and Internet Help Desk at (800) 541-5555. Please do not contact the Alliance.

Categories of Medi-Cal Eligibility: Aid Codes

Medi-Cal has more than 200 categories of eligibility, also known as aid codes. The Medi-Cal aid code is the two-digit number or combination of alpha and numeric characters that indicates the specific Medi-Cal program category under which the individual qualifies. DHCS, not the Alliance, establishes aid codes. Medi-Cal aid codes are assigned by county Medi-Cal eligibility staff, or by the state, based on federal and state guidelines for eligibility. Aid codes are added, deleted and revised periodically.

California Children Services – Whole Child Model Program

California Children’s Services (CCS) is a state program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children (ages 0 until the day before 21st birthday) who have CCS-eligible medical conditions. CCS-eligible medical conditions include -- but are not limited to -- chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, infectious diseases producing major sequelae, those that limit or interfere with physical function but can be cured, improved or stabilized (e.g., birth defects, handicaps present at birth or developing later, and injuries from accidents or violence).

These conditions tend to be relatively uncommon, chronic rather than acute, and costly. They generally require the care of more than one health care specialist. A comprehensive overview of CCS Medical Eligibility can be found on the DHCS website.

Historically, CCS services have been carved out of the Alliance and have been managed by the County in which the CCS member resides; however, on July 1, 2018, the Alliance assumed responsibility for most CCS services rendered to Alliance Medi-Cal members. This transition is called the Whole Child Model (WCM). The table below provides a general overview of the responsibilities of the Alliance, the county CCS program, and DHCS under the WCM.
Alliance Responsibility | County CCS Program Responsibility | DHCS Responsibility
--- | --- | ---
Reimburses providers for CCS services for Alliance members | Enrollment, disenrollment, eligibility determination and inter-county eligibility transfers for all CCS members (including Alliance members) | Panels providers, reviews and certifies CCS facilities and specialty care centers
Coordinates, reviews, and authorizes services for Alliance members | Manages appeals/grievances for disputes related to member eligibility for all CCS members (including Alliance members) |  
Case Management and Care coordination for Alliance members | Administers the Medical Therapy Program and the Pediatric Palliative Care Waiver | Reimburses providers for CCS services that are carved out from the Alliance (see Section 7: Carved out & Subcontracted Benefits & Services) or CCS services that are provided to non-Alliance members
Manages appeals/grievances for discontinuation or denial of services for Alliance members | Authorization, case management and care coordination for non-Alliance members |  

**Alliance Care In-Home Supportive Services**

The Alliance Care In-Home Supportive Services (IHSS) program provides health care coverage for Monterey County IHSS providers who work a specified number of hours per month. Eligibility is done by the Monterey County In-Home Supportive Service Program (IHSS) Public Authority. Enrollees pay monthly premiums to the Public Authority and pay copayments for some services.

All Alliance Care IHSS members are linked to a PCP from their first day of eligibility.

**Key Contact Numbers for Alliance Providers**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Department/Contact</th>
<th>Phone #</th>
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<tbody>
<tr>
<td>Referral Forms</td>
<td></td>
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<tr>
<td>Questions about Referral Forms</td>
<td>Health Services</td>
<td>(800) 700-3874 x 5506</td>
</tr>
<tr>
<td>Ordering Referral Forms</td>
<td>Provider Relations</td>
<td>(800) 700-3874 x 5504</td>
</tr>
<tr>
<td>Authorization Status</td>
<td>Health Services</td>
<td>(800) 700-3874 x 5511</td>
</tr>
<tr>
<td>Special Services</td>
<td></td>
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<tr>
<td>Non-emergency Transportation</td>
<td>Access Coordinator All Counties</td>
<td>(800) 700-3874 x5577</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>Health Programs All Counties</td>
<td>(800) 700-3874 x 5580</td>
</tr>
<tr>
<td>Case Management</td>
<td>Health Services All Counties</td>
<td>(800) 700-3874 x 5512</td>
</tr>
<tr>
<td>Claims Inquiries (9 a.m. – 4 p.m.)</td>
<td>Claims</td>
<td>(800) 700-3874 x 5503</td>
</tr>
<tr>
<td>Contract Questions</td>
<td>Provider Relations</td>
<td>(800) 700-3874 x 5504</td>
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<tr>
<td>Topic</td>
<td>Department/Contact</td>
<td>Phone #</td>
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<tr>
<td>Eligibility for Medi-Cal</td>
<td>Social Services</td>
<td>(888) 421-8080</td>
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<td></td>
<td>Santa Cruz County</td>
<td>(877) 410-8823</td>
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<td></td>
<td>Monterey County</td>
<td>(209) 385-3000</td>
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<td></td>
<td>Merced County</td>
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<tr>
<td>Mild-Moderate Mental Health Services</td>
<td>Beacon Health Options</td>
<td>(855) 765-9700</td>
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<tr>
<td>Vision Service Plan</td>
<td>VSP</td>
<td>(800) 877-7195</td>
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<tr>
<td>Denti-Cal</td>
<td>State Office</td>
<td>(800) 322-6384</td>
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<tr>
<td>Denti-Cal Provider Services</td>
<td>State Office</td>
<td>(800) 423-0507</td>
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<tr>
<td>DME Issues</td>
<td>Health Services All Counties</td>
<td>(800) 700-3874 x 5506</td>
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<tr>
<td>Pharmacy</td>
<td>Health Services All Counties</td>
<td>(800) 700-3874 x 5507</td>
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<tr>
<td>Concerns about 1099’s</td>
<td>Provider Relations</td>
<td>(800) 700-3874 x 2506</td>
</tr>
<tr>
<td>Health Education</td>
<td>Health Programs All Counties</td>
<td>(800) 700-3874 x 5580</td>
</tr>
<tr>
<td>Chief Medical Officer/ Medical Director</td>
<td>All Counties</td>
<td>(800) 700-3874 x 5588</td>
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**Eligibility Assistance**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Department/Contact</th>
<th>Phone #</th>
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<tbody>
<tr>
<td>Member Services</td>
<td>Member Services</td>
<td>(800) 700-3874 x 5505</td>
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<tr>
<td>Automated Eligibility System</td>
<td></td>
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<tr>
<td>State Automated Eligibility Verification System (AEVS) Eligibility and SOC</td>
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<td>(800) 456-2387</td>
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**Inquiries about Members or Member Services**

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<thead>
<tr>
<th>Topic</th>
<th>Department/Contact</th>
<th>Phone #</th>
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<tbody>
<tr>
<td>Reassignment of Member (PCP Only)</td>
<td>Provider Relations</td>
<td>(800) 700-3874 x 5504</td>
</tr>
<tr>
<td>Request for Administrative Member Status Due to Medical Condition</td>
<td>All Counties</td>
<td>(831) 430-5512</td>
</tr>
<tr>
<td>Missed Appointment/No-show Calls</td>
<td>Provider Relations</td>
<td>(800) 700-3874 x 5504</td>
</tr>
<tr>
<td>Member Services Representatives (verification of eligibility and PCP linkage)</td>
<td>Member Services</td>
<td>(800) 700-3874 x 5505</td>
</tr>
<tr>
<td>Provider Complaints and Grievances</td>
<td>Provider Relations</td>
<td>(800) 700-3874 x 5816</td>
</tr>
<tr>
<td>Recoveries or Other Insurance Recoveries</td>
<td>Finance</td>
<td>(800) 700-3874 x 5622</td>
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### Behavioral Health

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<th>County</th>
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<tr>
<td>Merced County</td>
<td>County Mental Health</td>
<td>(888) 334-0163 (209) 381-6800</td>
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<td>Department</td>
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<tr>
<td>Monterey County</td>
<td>County Mental Health</td>
<td>(888) 258-6029 (831) 755-5505</td>
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<td>Department</td>
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<tr>
<td>Santa Cruz County</td>
<td>County Mental Health</td>
<td>(800) 952-2335 (831) 454-4170</td>
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<td>Department</td>
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<tr>
<td>Mental Health Services</td>
<td>Beacon Health Options</td>
<td>(855) 765-9700</td>
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<td>for Medi-Cal members,</td>
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<td>Autism Spectrum Disorders</td>
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<td>Behavioral Health Treatment Services</td>
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<td>for Development Disorders</td>
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<tr>
<td>All Mental Health and</td>
<td>Beacon Health Options</td>
<td>(800) 808-5796</td>
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<tr>
<td>Substance Use Disorder</td>
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<td>Services for IHSS</td>
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### The Alliance Nurse Advice Line

| Health Care Answers     | Hearing or speech impaired members can contact the Nurse Advice Line through the Telecommunications Relay Service at (800) 735-2929 (TTY)/(800) 855-3000 (Spanish TTY) or (800) 854-7784 (Speech-to-Speech) or Dial 7-1-1. | (844) 971-8907 |
| 24 hours a day, 7 days a week |                                                                             | |
Participating in the Alliance Network

To participate in the Alliance network, a provider must sign a Provider Services Agreement and his/her credentials must be approved by the Medical Director or Peer Review and Credentialing Committee (PRCC). The PRCC is comprised of Alliance-contracted network physicians from major disciplines, including primary care and specialty practices. Providers are re-credentialed within 36 months after the initial credentialing date or the last re-credentialing approval date.

Pursuant to Article II of the Provider Services Agreement, all new providers and those eligible for re-credentialing must return a signed California Participating Physician Application (CPPA) to the Alliance, along with all required attachments, including, but not limited to, copies of the following documents:

- Current Medical License or Business License.
- Current Clinical Laboratory Improvement Amendments (CLIA) or Waiver, if applicable.
- Current Drug Enforcement Agency (DEA) License, if applicable.
- Documentation for National Provider Identifier (NPI) and Taxonomy Code.
- Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
- Signed Taxpayer Identification Form (W-9).
- Signed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form.
- Signed Declaration of Confidentiality form (new providers only).
- Curriculum vitae (with dates in MM/YYYY format)
- Hospital Privileges Status or Admitting Agreement
- Language Verification Form (new providers only).

If a provider is a supervising physician for a non-physician medical practitioner (NPMP), all new NPMPs and those eligible for re-credentialing must return a signed CPPA, along with all required attachments and copies of the following documentation:

- Current completed NPMP/Physician Assistant (PA) Delegation of Services Agreement(s), if applicable.
- Current NPMP staff licenses.
Current NPMP staff Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).

Signed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form.

Signed Declaration of Confidentiality form (new providers only)

In addition to the Alliance’s credentialing process, providers are required to complete screening and enrollment pursuant to the Department of Health Care Services (DHCS) guidelines. For more information, please see Alliance Policy 300-4025 – Provider Screening and Enrollment Process.

Before the verification process is finalized, a nurse from the Alliance will visit each Medi-Cal PCP site to conduct a site review. After the site review and verification of the credentialing information, the provider’s initial credentialing and re-credentialing files are submitted to the Medical Director or the PRCC for review and approval. If a provider’s credentials are approved, the Alliance’s Chief Executive Officer will countersign the Provider Services Agreement and within 10 business days of approval, new contracted providers will receive and complete new provider orientation training from the Alliance Provider Services Department. For more information, please see Policy 300-6030 – New Provider Training.

For additional information about the Alliance’s credentialing policies and procedures, please visit the credentialing policies link on the Alliance provider website.

Notification about Actions Taken Against Provider or Staff

Federal and state laws require that you notify us immediately by phone (with a follow-up in writing) of the following actions taken towards you or any practitioner on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification, or clinical privileges.
- A peer review action, inquiry or formal corrective action.
- A malpractice action or a government action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National Practitioner Data Bank of adverse credentialing or peer review action.
- Any material change in any of the credentialing information.
- Sanctions under the Medicare or Medicaid programs.
- Placement on the Medi-Cal Suspended and Ineligible Provider list.
- Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the agreement.
Appealing Adverse Decisions by the Peer Review and Credentialing Committee

If the PRCC should make a decision that alters the condition of a provider’s participation with the Alliance based on issues related to quality of care, the provider may appeal the adverse decision. For more information on the Alliance fair hearing process for adverse decisions, please see Policy 300-4103 - Fair Hearing Process for Adverse Decisions.

If a provider fails to meet the credentialing standards or if his/her license, certification or privileges are revoked, suspended, expired or not renewed, the Alliance must ensure that the provider not provide any services to Alliance members. Additionally, any conduct that could adversely affect the health or welfare of a member will result in written notification instructing the provider not to provide services to Alliance members until the matter is resolved to our satisfaction.

Review Procedure for Decisions Concerning Provider Network Participation

If the Alliance should make a decision that alters the condition of a provider’s participation with the Alliance for reasons not related to quality of care, a provider’s failure to meet the licensing, certification or authority requirements of the Provider Services Agreement, or a provider being either excluded from participating in, or sanctioned by, the Medicare or Medicaid programs, the provider may be heard through the Alliance review procedure. This review procedure is the provider fair hearing right described in the Provider Services Agreement. For more information on the provider review procedure, please see Policy 300-9010 - Review Procedure for Decisions Concerning Provider Network Participation.

Please note that in no event would a provider have access to both the Fair Hearing Process for Adverse Decisions and the Review Procedure for Decisions Concerning Provider Network Participation with respect to the same decision.

Changes in Ownership

Generally, Alliance provider agreements require that the provider obtain prior written consent from the Alliance when a change of ownership is planned. Additionally, where a change in ownership results in the desire to assign an Alliance agreement to another entity, written approval from the California Department of Health Care Services must be obtained prior to such assignment occurring. Depending upon the circumstances of the change in ownership, it is also possible that a provider’s eligibility for incentives may be impacted.

If you anticipate a change in ownership of your organization, please complete the Notice of Change in Ownership document and return it to the Alliance as soon as possible to help ensure that your contract with the Alliance remains in force and accurate.

Debarment, Suspension, Ineligibility or Voluntary Exclusion

In accordance with the Code of Federal Regulations, Title 45, Part 76 (45CFR76), the Alliance receives federal funding and therefore must certify that it has not been debarred or otherwise excluded from receiving these funds. Under this rule, because the Alliance receives this federal funding, the Alliance is considered a “lower tier participant.” As subcontractors, our providers, who essentially receive federal
Section 2. Credentialing, Contracting and Compliance

funding by nature of their Agreement with the Alliance, are also considered “lower tier participants” and thus must also attest to the fact that, by signing the form specified below, they have not been debarred or otherwise excluded by the federal government from receiving federal funding.

When providers apply to become part of the Alliance network, they receive a form titled “Certification Regarding Debarment Suspension, Ineligibility and Voluntary Exclusion.” This form must be signed by the provider and returned with a completed credentialing application and signed agreement, certifying, as stated above, that the provider is eligible to participate in the Alliance program and receive funds provided by the federal government. Pursuant to this certification and provider agreement with the Alliance, should the provider, or any other subcontracted provider, become suspended or ineligible to receive federal funds, the provider is required to notify the Alliance immediately.

Debarment, Suspension, Ineligibility of Prescribing Providers

In accordance with California Civil Code, Section 51303(k), the Alliance cannot reimburse providers for services ordered, prescribed, or rendered by a provider who is debarred, suspended, or otherwise ineligible from participation in the Medi-Cal program or included on federal debarment and suspension lists. Accordingly, should the Alliance receive a claim for payment, or retrospectively identify payment of a claim, resultant from the order or prescription of a debarred, suspended, or otherwise ineligible provider, such a claim would be unallowable and subject to denial or recoupment, respectively.

For more information, please see Policy 105-3003 – Suspended or Ineligible Providers.

Program Integrity: Anti-Fraud, Waste and Abuse

Alliance anti-fraud, waste and abuse (FWA) efforts encompass two primary activities: FWA prevention and investigation, collectively known as Program Integrity.

Definitions

Abuse: Activity that is inconsistent with sound fiscal, business, or medical practice standards and results in unnecessary cost or reimbursement. It also includes any act that constitutes abuse under applicable federal law (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.

Waste: The consumption of resources (products or services) due to mismanagement, inappropriate actions or inadequate oversight. Waste is not typically the result of criminal actions.

Laws and Regulations

False Claims Act (Federal – 31 U.S.C. § 3729-3733; California – C.G.C. § 12650-12656): The California and Federal False Claim Acts (FCAs) make it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs’ loss plus $11,000 per claim. Under the civil FCA, no specific intent to defraud is required. The civil FCA defines “knowing” to include not only actual knowledge but also instances in which the person
acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries. There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines.

For additional anti-FWA laws and regulations that inform the Alliance’s Program Integrity efforts, please review Policy 105-3001 - Program Integrity: Fraud Waste and Abuse Prevention Program.

**Fraud Waste & Abuse Prevention**

Alliance FWA prevention (FWAP) activities are facilitated by the Alliance FWAP Program. The FWAP Program ensures:

- Written policies, procedures and standards for all employees (including management) and any contractor or agent (including providers), that: articulate the Alliance’s commitment to comply with all applicable federal and state anti-FWA standards; outline the procedures for preventing, detecting potential/actual FWA; and, provide detailed information about the FCA, administrative remedies for false claims, state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting FWA.

- Employee handbook inclusion of information about the FCA and related laws, the rights of employees to be protected as whistleblowers and Alliance policies and procedures for detecting and preventing FWA.

- The establishment of an anti-FWA program with a central point of contact.

- Provision for internal monitoring and auditing.

- Alliance Compliance Officer and employees receive and complete effective training on FWA prevention, detection and reporting.

- The Alliance does not employ or contract with individuals debarred, proposed for debarment, suspended, declared ineligible or voluntarily excluded by any federal department or agency.

- The Alliance’s appropriate use of non-monetary incentives to promote good member health practices.

The FWAP Program promotes:

- Board member, employee and contractor compliance with Alliance FWAP-related policy, and regulatory, contractual and legislative requirements governing the health plan, including the Alliance Code of Conduct and Oath of Confidentiality.

- Member protection in the receipt of health care services through timely detection of potential/actual FWA.

- The protection, security and confidentiality of protected health information.

- Contractor development and maintenance of internal FWAP program and policy.
• Alliance board, contractor/provider and member understanding and awareness of FWA practices through education and information sharing.

• Prompt reporting by Alliance board members, employees and contractors of suspected/actual violations of any FWA-related statute, regulation or guideline applicable to federal and/or state health care programs or Alliance policies.

• Alliance employees maintain awareness and protection of the legal rights of all parties involved in any case of potential/actual FWA.

• A system of internal assessment is organized and maintained to identify and analyze significant opportunities for FWAP program improvement.

• Recognition of Alliance board members, employees, providers, contractors, members, local law enforcement and the state as important partners in this effort.

The Alliance’s FWAP program integrates the activities of all Alliance departments in meeting our FWAP objectives. The FWAP program is one of the many ways the Alliance ensures: appropriate service provision to our members; partnerships with reputable contractors; and, proper administration of our health plan, including correct use of public funds. The Alliance takes the position that fraud, waste and abuse at any level are impermissible and intolerable. When a practice is deemed not consistent with Alliance standards and requirements, an investigation may be performed and an action plan developed, as needed.

Fraud Waste & Abuse Investigations

Investigations into suspected/actual FWA are facilitated by the Alliance Special Investigations Unit (SIU). The SIU will only investigate FWA concerns relating/potentially relating to Alliance members, health care providers, non-health care contractors, employees, or Board members. Should the Alliance become aware of potential/actual FWA not related to Alliance entities, the Alliance may facilitate referral to appropriate agencies. The SIU ensures:

• Prompt and complete investigation of suspected/actual FWA. The SIU undertakes research and data analysis, internally and potentially externally, when necessary.

• Reporting of investigative findings to the state and/or law enforcement, as appropriate, when there is reason to believe fraud and/or abuse has occurred by contractors, members, providers, or employees. For the Alliance’s Medi-Cal program, potential/actual fraud or abuse concerns will be reported to California Department of Health Care Services (DHCS) within 10 business days; provider-related concerns will also be reported to the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, and/or other applicable law enforcement agencies.

• Development of corrective action plans, including the recoupment of identified overpayments, when indicated by investigative findings.

For additional information, please view Policy 105-3002 – Program Integrity: Special Investigations Unit Operations.

If you have any concerns about practice standards or general questions about Alliance Program Integrity efforts, please contact your Provider Relations Representative.
Medical Records

Each primary care office is responsible for maintaining adequate medical records of patient care. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for ten years after termination of agreement with the Alliance, including the period required by the Knox-Keene Act and Regulations, and Medicare and Medi-Cal programs.

To ensure compliance with medical record keeping requirements, the Alliance periodically performs audits of network providers for billed services. For additional information about this process, see Policy 105-3004 - Verification of billed Services by Network Providers.

Confidentiality of Information

Providers are responsible for ensuring and maintaining the confidentiality of information about members and their medical records, in accordance with applicable federal and state laws. The names of any member receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records, and data collected and maintained for the operation of the Agreement including information accessed through the Alliance Provider Portal. Providers may not use any such information for any purpose other than carrying out the terms of their agreement. In compliance with The Health Insurance Portability and Accountability Act (HIPAA), members are entitled to an accounting of any disclosure of information. If an unauthorized disclosure of member information occurs, providers are to notify the Alliance immediately upon discovery by faxing the following information to the Alliance Compliance Department at (831) 430-5680.

- Provider office name, contact person and phone number
- Date the disclosure occurred
- Date the disclosure was discovered
- Number of Alliance members affected
- Identification numbers of affected Alliance members
- How the unauthorized disclosure occurred (fax, email, etc.)
- Who the information was disclosed to
- What information was disclosed (first/last name, identification number, phone number, address, diagnosis/procedure code, etc.)
- How the disclosure was discovered
- Description of what occurred

Medical Record Keeping

The Alliance’s provider agreements require medical records be maintained in a manner that is current and demonstrates the Medical Necessity of Covered Services for which a claim for payment is submitted. As a
minimum standard, practitioners billing the Alliance for Covered Services must document the provision of such services in the member’s medical record prior to submitting a claim for payment. The Alliance may recoup payments where it identifies that no documentation of the service exists in the member’s medical record.

**Access to and Copies of Records**

Providers are required to have records readily retrievable for all billed services regardless of rendering location. Our Health Services and/or Compliance staff may request records from provider offices for one or more Alliance covered members for several reasons, including:

- Quality improvement studies mandated by the Medi-Cal Managed Care Division.
- Authorization requests.
- Claims’ payments issues.
- Assistance with case coordination.
- Determination of “requests for administrative member” status.
- Possible California Children’s Services (CCS) referrals.
- Follow-up to a member complaint or quality of care issue.
- Evaluation of potential fraud/abuse concerns.
- Verification that medically necessary goods/services were received by Alliance members.
- Assistance facilitating a medical record review audit.

For complete details on provider responsibilities relative to medical records, please see Policy 401-1510 - Medical Record Review and Requirements.

**Accessibility Standards**

Providers’ requirement to provide timely access to health care will be ensured through a monitoring process using acceptable performance standards. After hours availability standards are described in Policy 404-1202 – After-Hours Availability of Plan and Contract Physician. Additional access standards can be found in Policy 401-1509 - Timely Access to Care and Policy 300-8030 - Monitoring Network Compliance with Accessibility Standards.

**Unlawful Harassment**

Provider as well as its agents and employees, shall not unlawfully harass or allow harassment against any Alliance Member or their representative. For the purpose of this provision, Harassment means conduct that has the purpose or effect of unreasonably interfering in a substantial manner with an individual's welfare, or creates an intimidating, hostile, offensive, or demeaning environment. Harassment includes, but is not limited to, the following examples of behavior:
• Physical harassment: assault, touching, impeding or blocking movement, grabbing, patting, leering, making express or implied job-related threats in return for submission to physical acts, mimicking, taunting, or any physical interference with normal movement.

• Sexual harassment: may involve the behavior of a person of either sex against a person of the opposite or same sex, and occurs when such behavior constitutes unwelcome sexual advances, unwelcome requests for sexual favors, and other unwelcome verbal, physical, or visual behavior of a sexual nature where:
  o Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's treatment;
  o Submission to or rejection of such conduct by an individual is used as the basis for decisions affecting the individual's welfare; or
  o Such conduct is so severe or pervasive as to alter the environment in a negative or hostile way.

• Verbal harassment, such as epithets (nicknames and slang terms), derogatory or suggestive comments, propositioning, jokes or slurs, intimidation, threats, gestures, flirtations, or graphic verbal commentaries about an individual’s body or appearance. Verbal harassment includes patronizing or ridiculing statements that are disparaging and bullying.

• Visual forms of harassment, such as derogatory posters, notices, photographs, bulletins, cartoons, drawings, sexually suggestive objects, or inappropriate electronic communications such as email or texts.
Section 3
The Role of the Primary Care Provider

Primary care providers (PCPs) are responsible for providing the full scope of primary care services to their Alliance members. As a PCP, your role is vital in the overall coordination of health care for each member in your practice, and in providing health care services. As a PCP, you are responsible for:

- Ensuring or facilitating members’ access to the health care system, preventive care, and appropriate treatment interventions.
- Assessing each member’s health status, including an Initial Health Assessment (IHA) for each new member within 120 days after his/her enrollment (see below).
- Providing quality primary care health services.
- Initiating and coordinating referrals to specialists or other participating providers as needed.
- Assuring that members in your practice are not discriminated against in the delivery of services based on race, ethnicity, national origin, spoken language, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, and/or source of payment.
- Assuring that no unnecessary or duplicate medical services are being provided. For additional information about unnecessary or duplicate medical services, see Policy 404-1108 - Monitoring of Over/Under Utilization of Services.
- Establishing a good medical records system for tracking, recall, and identifying any clinical problems unique to your particular patient population.
- Determining the number of Alliance members your practice can accept. The number of members linked to your practice will be monitored by the Alliance to ensure that members have timely access to care through credentialed providers. For more additional information on capacity and capacity monitoring see Policy 300-8040 - Monitoring PCP Capacity.

Facility Site Review and Medical Record Review

The Alliance conducts Facility Site Reviews (FSRs) for new Medi-Cal PCPs at the time of initial credentialing, at least every three years thereafter per California Department of Health Care Services (DHCS) guidelines, and as part of the re-credentialing process, regardless of the status of other accreditation and/or certifications. PCPs must notify the Alliance at least 30 days prior to a physical move or expansion of their clinic so an FSR may be conducted at the new site, as specified in Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. There are three components to the FSR process:

1. The Facility Site Review survey (MMCD PL 14-004 Attachment A).
2. The Medical Record Review survey (MMCD PL 14-004 Attachment B).

Attachments A and B are scored reviews. Attachment A reviews the physical aspects of the site for basic regulatory requirements in areas such as: access, safety, personnel, office management, infection control, and pharmaceutical/lab/preventive services. Attachment B is conducted three to six months after initial member linkage and focuses entirely on the medical record for format, documented evidence of coordination and continuity of care and appropriate preventive health care services provided. Attachment C is not a scored review, and focuses entirely on physical accessibility of the clinic for all Alliance members, including Seniors and Persons with Disabilities (SPDs).

Any Corrective Action Plans (CAPs) that result from the scored reviews must be addressed within the established CAP timelines. The Alliance assists sites with their CAPs by providing education, answering questions, and offering resources whenever possible. Providers that do not meet CAP timelines, as specified in MMCD Policy Letter 14-004 timelines, are required to be removed from the network.

Additionally, provider sites that score 79% and below in either Attachment A or B for two consecutive reviews must score a minimum of 80% in the next review for both Attachments A and B. Sites that do not score a minimum of 80% for the third consecutive review, are required to be removed from the network.

For more information on Facility Site Reviews, please see Policies 401-1508 - Facility Site Review Process and 401-1521 - Physical Accessibility Review.

The scoring sheets and guidelines for Attachments A and B can be found on the Alliance provider website.

More information and the survey for Attachment C can be found on our Physical Accessibility Review page on the provider website.

**Primary Care Provider Selection**

Every new Alliance Medi-Cal member will be provided an opportunity to select a PCP within the first 30 calendar days of enrollment. The member may communicate their PCP selection to the Alliance by phone, mail, fax, or through the Alliance website. If the member does not choose a PCP by the end of that period, they will be auto-assigned to a PCP. The auto-assignment logic looks at the following factors when doing PCP assignment: zip code, age, gender, language, family linkage and provider status. Alliance Care IHSS members are assigned to a PCP as of their effective date.

If an Alliance Medi-Cal member is eligible for the CCS program or receives Medi-Cal under an SPD aid code, they may choose a specialist as their PCP.

**Initial Health Assessment**

The Medi-Cal Managed Care Division of the California Department of Health Care Services (DHCS) requires that each PCP complete an Initial Health Assessment (IHA) for all of his/her linked Medi-Cal members within 120 days of the member’s enrollment. At a minimum, an IHA must include the following: comprehensive history, preventive services, comprehensive physical with mental status exam, diagnoses and plan of care, and an Individual Health Education Behavioral Assessment (IHEBA) using the Staying Healthy Assessment (SHA) or other DHCS-approved tool.
The SHA and related instructions can be found on the Alliance IHA Resources Page and the CBI Resources Page.

Refer to MMCD Policy Letter 08-003 for requirements on IHA components. It is the providers’ responsibility to code appropriately. Please visit the provider website for the 2017 IHA Billing Code List.

For more information on IHA criteria, please see Policy 401-1511 - Initial Health Assessment.

**Early and Periodic Screen, Diagnosis and Treatment (EPSDT)**

PCPs are required to ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

For more information on coordinating EPSDT services, please see Policy 404-1313 – Primary Care Provider Responsibilities in Case Management and the Promotion of Primary Care Medical Home.

**Preventive Care**

PCPs are required to provide preventive health care according to nationally recognized criteria. Please visit the provider website for assistance with preventive care guidelines for either children or adult patients. Alliance prevention guidelines for healthy, asymptomatic adults are based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF). All preventive services identified as USPSTF “A” and “B” recommendation must be provided. Alliance prevention guidelines for children are based on recommendations of the American Academy of Pediatrics (AAP) Bright Futures Guidelines and Child Health and Disability Prevention (CHDP) standards. Alliance immunization guidelines for adults and children are based upon recommendations of Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (CDC-ACIP).

For more information on Adult Preventive Care, please see Policy 401-1502 - Adult Preventive Care.

For more information on Child Preventive Care, please see Policy 401-1505 - Childhood Preventive Care.

For more information on Immunization Services and Reimbursement, see Policy 401-1506 – Immunization Services and Reimbursement.

For the CDC recommended immunization schedule for adults and children, please visit the CDC website.

**Alcohol Misuse: Screening and Behavioral Counseling (AMSC)**

As part of the comprehensive preventive care program, effective with dates of service on or after January 1, 2014, PCPs are required to offer Alcohol Misuse: Screening and Behavioral Counseling (AMSC) services to all adult members (18 years and older) related to alcohol misuse as recommended by the US Preventive Services Task Force (USPSTF). AMSC should be provided to members who respond affirmatively to the alcohol pre-screen question on the SHA or those who the PCP otherwise identifies as having risky or hazardous alcohol use. For those members who respond affirmatively to pre-screening, the Alcohol Use Disorder Identification Test – Consumption (AUDIT-C) or other validated alcohol screening questionnaire
should be administered. For members who respond affirmatively to the AUDIT-C or other validated screening tool, PCPs will offer alcohol use brief interventions (up to three 15 minute sessions in person or by phone) or refer members identified with possible alcohol use disorders to the alcohol and drug program in the county where the member resides for further evaluation and treatment.

<table>
<thead>
<tr>
<th>Santa Cruz County Behavioral Health Access</th>
<th>(800) 952-2335 or (831) 454-4170</th>
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<tbody>
<tr>
<td>Monterey County Behavioral Health Access</td>
<td>(888) 258-6029 or (831) 755-5505</td>
</tr>
<tr>
<td>Merced County Behavioral Health Access</td>
<td>(888) 334-0163 or (209) 381-6880</td>
</tr>
</tbody>
</table>

Per United States Preventive Services Task Force (USPSTF) guidelines, providers should screen adults ages 18 years or older for alcohol misuse. Each member is eligible for three screenings annually, as well as additional screenings if considered medically necessary. Brief intervention(s) typically include one to three sessions, and may be offered in-person, by telephone, or via telehealth. Members that are engaged in risky or hazardous drinking shall be provided with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services, as medically necessary. Members are eligible for at least three brief interventions sessions per year. These sessions may be combined in one or two visits or administered as three separate visits and may be provided on the same date of service as the screening or on subsequent days. More information regarding screening and brief intervention is available on the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website. For more information also see Policy 404-1313 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

**Enhanced Primary Care Pain Management Program**

The Enhanced Primary Care Pain Management Program has been developed to increase access to pain management services from Primary Care Providers for their linked Medi-Cal members. Such services are for the purpose of supporting primary care providers in offering Medication Assisted Treatment (MAT) for members on high doses of opioid medications for chronic non-cancer pain and with opioid use disorder or substance use disorder.

**Eligible Members**

Members eligible for the program include a provider's linked Medi-Cal members with an ICD-10 diagnosis of F11 through F11.99.

**Eligible Providers**

To be eligible to provide services under the program, rendering physicians must 1) be credentialed under a Primary Care Physician Services Agreement, and 2) have DEA X-licensure (DATA Waiver). In addition to meeting these requirements (credentialed and DEA X-licensure), rendering physician assistants and nurse practitioners must also be supervised by a physician that has DEA X-licensure.
Eligible Services

Eligible services under the program include initial and follow-up consultative evaluation and management services for the treatment of concerns related to opiate use, that meet the additional requirements described below.

Initial Visit

- History and physical exam;
- Assessment of cause of pain, current treatment regimen and any co-occurring substance abuse disorder;
- Development of a plan of care regarding MAT;
- Communications and follow-up with the Alliance regarding the Member’s condition; and
- Must be billable under CPT codes 99204 or 99205

Follow-Up Visits

- MAT management;
- Services vary in duration and content depending on circumstances; and
- Must be billable under CPT codes 99212 through 99215

Services for each member entering the program must receive prior authorization from the Alliance, and otherwise be considered covered services under the provider’s Primary Care Physician Services Agreement to be considered payable under the program. Authorization requests for services provided by physician assistants and nurse practitioners must be submitted under the provider’s supervising physician, and billed under their supervising physician as well. Authorization under the program will not exceed one year in duration. Services rendered after the one-year expiration date will require a new authorization to remain in the program. There is no limit to the number of sequential authorizations requested.

To receive reimbursement for program services, the provider must include the authorization number on the claim form.

Compensation

Eligible program services provided by program eligible providers to program eligible members as described above are not considered Primary Care Physician Services subject to case management and will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement as applicable. For more information, please see Policy 404-1731 - Medication Assisted Treatment.

Seniors and Persons with Disabilities

DHCS has requirements for providers treating the Seniors and Persons with Disabilities (SPD) population. These requirements are part of the Medi-Cal 2020 Waiver.
Health Risk Assessments

All newly-enrolled Medi-Cal only SPD members (excluding those who are dually-eligible for Medicare and Medi-Cal and those with other health care coverage) will receive a Health Risk Assessment (HRA) within 44 days of enrollment with the plan. The Alliance will administer the HRA either telephonically or by mail. All HRAs will be conducted in the member’s preferred language. Members will be stratified into high- and low-risk, with high-risk members being offered Alliance Care Management Services for complex case management. Administering the HRA and coordinating follow-up care is not the responsibility of the PCP, but you will be notified regarding which members are receiving Alliance case management services. The HRA does not take the place of the Initial Health Assessment (IHA). The IHA is required for all new members and must be conducted within 120 days after the member’s enrollment with the Alliance.

Specialists as PCPs

Specialists are eligible to act as PCPs for SPD members and members who are eligible for CCS. Members are linked to the provider’s panel. To become an SPD or CCS PCP, providers need to meet the needs of the member within the scope of their practice, have a contract, and be credentialed. Provider offices will also have to undergo and pass a Facility Site Review as part of the credentialing process.

Sensitivity Training

All providers must receive sensitivity training to better meet the needs of the SPD population. In addition to periodic workshops, sensitivity training materials may be found on the Alliance provider website.

Physical Accessibility Review

All PCPs, high volume specialists, and ancillary providers will be surveyed for physical accessibility. The Physical Accessibility Review (PAR) is an informational survey that will evaluate accessibility in the following categories: parking, building exterior, building interior, restroom, exam room and medical equipment (height adjustable exam tables, patient accessible weight scales, equipment used for diagnosis and treatment). Results of the survey will be made available to providers and are published in the Provider Directory. Your practice site will be listed as either having Basic Access or Limited Access. The first PAR will take place as part of the initial credentialing process, or as soon as practical for existing PCPs and identified high volume specialists. Subsequent PARs will occur every three years, unless significant physical changes are made to the provider site. For more information about the PAR, please visit the Alliance website, as well as see Policy 401-1521 - Physical Accessibility Site Review.

For additional information regarding SPDs, see Policy 405-1112 - Care Management of Seniors and Persons with Disabilities for Medi-Cal.

For additional information regarding complex case management, see Policy 405-1113 - Care Management Complex Case Management.

Comprehensive Tobacco Cessation Services

PCPs are responsible for screening for smoking and tobacco use for all patients (of any age), providing counseling, and making appropriate referrals. Smoking and tobacco use counseling must be provided by a physician or other qualified health professional face-to-face. Supporting documentation is required for any
office audit for codes 99406 (smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes). Please note: 99407 is not to be billed in conjunction with 99406. Documentation must include the total time spent with the patient and what was discussed, including cessation techniques, resources offered, and follow-up. Counseling lasting less than three minutes is considered part of an Evaluation and Management (E&M) service (e.g. 99201-99215), not paid separately and not covered by 99406 and 99407. For additional information about this benefit and the Alliance Tobacco Cessation Support Program (TCSP), please see Policy 405-2217 - Comprehensive Tobacco Cessation Services or refer to Section 13: Health Education and Disease Management Programs.

Utilization Management Program

PCPs are accountable for aspects of the Alliance Utilization Management program within their scope of practice. For information on the program, please see Policy 404-1101 - Utilization Management Program.

Case Management

Primary Care Physician Services

The services listed below are the Primary Care Physician Services to be provided by PCPs in accordance with the Case Management of a linked member. Providers shall administer these Primary Care Physician Services as medically necessary, unless this service is outside the scope of the medical services rendered by the provider. If the provider is paid on a capitation basis for Primary Care Physician Services, and an on-call or covering PCP sees a member linked to another provider, the Alliance will not pay the on-call or covering provider in addition to the capitation payment for the services listed below.

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>Office Visit</td>
<td>New Patient</td>
</tr>
<tr>
<td>99201</td>
<td>Problem focus history; 10 minutes</td>
</tr>
<tr>
<td>99202</td>
<td>Expanded problem focus; 20 minutes</td>
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<tr>
<td>99203</td>
<td>Detailed history, low complexity; 30 minutes</td>
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<tr>
<td>99204</td>
<td>Comprehensive history and exam; moderate complexity; 45 minutes</td>
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<td>99205</td>
<td>Comprehensive history and exam; high complexity; 60 minutes</td>
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Office Visit | Established Patient                                |
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<tr>
<td>99211</td>
<td>Minimal problem; physician supervised services; 5 minutes</td>
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<tr>
<td>99212</td>
<td>Problem focus history and exam; 10 minutes</td>
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<td>99213</td>
<td>Expanded problem focus history and exam; 15 minutes</td>
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<tr>
<td>99214</td>
<td>Detailed history and exam, moderate complexity; 25 minutes</td>
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<tr>
<td>99215</td>
<td>Comprehensive history and exam; high complexity; 40 minutes</td>
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### Prevention

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<tbody>
<tr>
<td>99381</td>
<td>New patient, infant evaluation</td>
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<tr>
<td>99382</td>
<td>Early childhood, age 1 to 4 years old</td>
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<tr>
<td>99383</td>
<td>Late childhood, age 5 to 11 years old</td>
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<tr>
<td>99384</td>
<td>Adolescent, age 12 to 17 years old</td>
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<tr>
<td>99385</td>
<td>18 to 39 years</td>
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<tr>
<td>99386</td>
<td>40 to 64 years</td>
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<tr>
<td>99387</td>
<td>65 years and older</td>
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### Prevention

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<th>Description</th>
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<tbody>
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<td>99391</td>
<td>Established patient, infant, periodic reevaluation</td>
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<td>99392</td>
<td>Early childhood, age 1 to 4 years old</td>
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<tr>
<td>99393</td>
<td>Late childhood, age 5 to 11 years old</td>
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<tr>
<td>99394</td>
<td>Adolescent, age 12 to 17 years old</td>
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<tr>
<td>99395</td>
<td>18 to 39 years</td>
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<td>99396</td>
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### Other Evaluation and Management

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<td>99354</td>
<td>Prolonged Physician Service; Office or Outpatient setting; first hour</td>
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<tr>
<td>99355</td>
<td>Prolonged Physician Service; Office or Outpatient setting; each additional 30 minutes</td>
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### Emergency Room

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<th>Level</th>
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<tr>
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</tr>
<tr>
<td>99285</td>
<td>ER Level 5</td>
</tr>
</tbody>
</table>

### Minor Surgical Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11900</td>
<td>Injection; intralesional up to 7 lesions</td>
</tr>
<tr>
<td>11901</td>
<td>More than 7 lesions</td>
</tr>
<tr>
<td>16000</td>
<td>Initial treatment for 1st degree burns</td>
</tr>
<tr>
<td>16020</td>
<td>Dressing and/or debridement of burns; small</td>
</tr>
<tr>
<td>16025</td>
<td>Dressing and/or debridement of burns; medium</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>16030</td>
<td>Dressing and/or debridement of burns; large</td>
</tr>
<tr>
<td>46600</td>
<td>Diagnostic Anoscopy</td>
</tr>
<tr>
<td>51701</td>
<td>Insertion of non-indwelling bladder catheter (e.g., straight catheterization for residual urine)</td>
</tr>
<tr>
<td>51703</td>
<td>Insertion of temporary indwelling bladder catheter, complicated (e.g., altered anatomy, fractured catheter/balloon)</td>
</tr>
<tr>
<td>54055</td>
<td>Electrodesiccation</td>
</tr>
<tr>
<td>69200</td>
<td>Clear outer ear canal</td>
</tr>
<tr>
<td>69210</td>
<td>Removal impacted cerumen</td>
</tr>
<tr>
<td></td>
<td><strong>Injections</strong></td>
</tr>
<tr>
<td>20550</td>
<td>Injection; single tendon sheath or ligament</td>
</tr>
<tr>
<td>20610</td>
<td>Arthrocentesis, aspiration or injection, major joint or bursa only</td>
</tr>
<tr>
<td></td>
<td><strong>Collection/Handling Blood</strong></td>
</tr>
<tr>
<td>36400</td>
<td>Venipuncture, age 3 or under</td>
</tr>
<tr>
<td>36405</td>
<td>Scalp vein</td>
</tr>
<tr>
<td>36410</td>
<td>Venipuncture, over age 3</td>
</tr>
<tr>
<td>36420</td>
<td>Venipuncture, under age 1</td>
</tr>
<tr>
<td>36425</td>
<td>Age 1 and over</td>
</tr>
<tr>
<td>99000</td>
<td>Handling and/or conveyance of specimen for transfer from the physician’s office to a laboratory</td>
</tr>
<tr>
<td></td>
<td><strong>Vision and Hearing</strong></td>
</tr>
<tr>
<td>92081</td>
<td>Visual field exam</td>
</tr>
<tr>
<td>92551</td>
<td>Screening test, pure tone</td>
</tr>
<tr>
<td>92552</td>
<td>Pure tone audiometry</td>
</tr>
<tr>
<td>92553</td>
<td>Air and bone</td>
</tr>
<tr>
<td>92555</td>
<td>Speech audiometry</td>
</tr>
<tr>
<td>92556</td>
<td>Threshold and discrimination</td>
</tr>
<tr>
<td>92557</td>
<td>Basic comprehensive audiometry</td>
</tr>
<tr>
<td>92567</td>
<td>Tympanometry (impedance testing)</td>
</tr>
<tr>
<td></td>
<td><strong>Allergy Immunotherapy</strong></td>
</tr>
<tr>
<td>95115</td>
<td>Single injection</td>
</tr>
<tr>
<td>95117</td>
<td>Multiple use allergy injections</td>
</tr>
</tbody>
</table>
Section 3. The Role of the Primary Care Provider

95199  Unlisted allergy immunology services

**ECG, Other Miscellaneous Test, Supplies**

93000  Electrocardiogram
93005  Tracing only, without interpretation or report
93010  Interpretation and report only
93040  Rhythm ECG with report
93041  Rhythm ECG, tracing
93042  Rhythm ECG, report
94150  Vital capacity
94640  Inhalation treatment
95017  Allergy testing, with venoms
95018  Allergy testing, with drugs or biological
95052  Photo patch tests
95070  Bronchial allergy tests
97799  Unlisted physical medicine
99070  Special supplies

**Notes**

California Children Services (CCS) program services provided by CCS approved physicians, for the treatment of an Alliance Medi-Cal member’s CCS eligible condition, are not considered Primary Care Physician Services subject to case management. These services will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement, as applicable, subject to authorization requirements.

Children's Health and Disability Prevention (CHDP) services provided by CHDP enrolled providers to Medi-Cal members are not considered Primary Care Physician Services subject to Case Management. Providers shall bill the Alliance separately for these services and will be paid fee-for-service rates as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any referral and authorization requirements.

Comprehensive Perinatal Services Program (CPSP) services provided to Medi-Cal members are not considered Primary Care Physician Services subject to Case Management and will be paid fee-for-service rates by Plan as set forth in the Primary Care Physician Services Agreement as applicable, subject to any authorization requirements.

Enhanced Primary Care Pain Management Program services provided to members eligible under the program, by providers who are eligible to participate in the program are not considered Primary Care Physician Services subject to Case Management. These services will be paid fee-for-service rates by the Alliance as set forth in the Primary Care Physician Services Agreement as applicable, subject to authorization requirements.
Palliative Care services provided to Medi-Cal members are not considered Case Managed Primary Care Physician Services and will be paid fee-for-service rates by Plan as set forth in the Primary Care Physician Services Agreement, as applicable, subject to any authorization requirements. Providers must include a U1 modifier in the first position for every code submitted for Palliative Care services on the claim.

For more information on physician case management responsibilities, please see Policy 404-1313 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.
Section 4
Enrollment and Eligibility

Medi-Cal

Individuals and families apply for Medi-Cal through their county Human Services/Social Services Department and through Covered California. Applications may be done in person, online, through the mail or over the phone. Individuals who receive Supplemental Security Income (SSI) automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month to month. Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a member’s eligibility must be verified before delivery of services and that the Alliance identification card alone is not a guarantee of eligibility.

Eligibility for CCS is determined by the County CCS program in the county in which the member resides, CCS eligibility information is available in the State Children’s Medical Services Network (CMS Net) Provider Electronic Data Interchange (PEDI) and is visible in the Alliance portal.

Timing of Eligibility through Fee-For-Service Medi-Cal and the Alliance

Not all Medi-Cal beneficiaries in Santa Cruz, Monterey, and Merced counties are Alliance members. Those that are not Alliance members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Affiliated Computer Services, the state Medi-Cal fiscal intermediary. Any necessary prior authorization for elective services (referred to as an “Authorized Referral Request,” formerly known as “Treatment Authorization Request” or “TAR”) for Medi-Cal beneficiaries not covered by the Alliance should be submitted to the Medi-Cal field office, not to the Alliance.

FFS Medi-Cal beneficiaries with CCS eligible conditions are not Alliance members. Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Electronic Data Systems (EDS). Any necessary authorization for CCS services (referred to as a “Service Authorization Request”) for FFS Medi-Cal beneficiaries with CCS eligible conditions should be submitted to the local county CCS Program.

Newly eligible Medi-Cal beneficiaries are covered through FFS Medi-Cal for at least their initial month of eligibility and, depending on when during the month they became eligible, could be covered under FFS for the following month as well. If they requested and received eligibility for any prior months, known as retroactive eligibility, those months would also be covered through FFS Medi-Cal. Newly eligible Medi-Cal beneficiaries will not become Alliance members until the first of the month following their enrollment as long as their eligibility is processed in time to be transmitted to the Alliance by the state in a month end eligibility file. For example:
A Medi-Cal applicant is determined eligible on June 3: Once eligibility is determined, eligibility will be effective as of June 1. The beneficiary will be covered through FFS Medi-Cal for the month of June. Alliance enrollment will begin on July 1.

A Medi-Cal applicant is determined eligible on June 26: Once eligibility is determined, eligibility will be effective as of June 1. The beneficiary will be covered through FFS Medi-Cal for the months of June and July. Alliance enrollment will begin on August 1.

In addition, the Alliance may be responsible for services provided to an Alliance Medi-Cal member whose annual eligibility redetermination occurs within 60-days after the member’s annual eligibility redetermination date. If the member completes the redetermination process within 60 days after their eligibility redetermination date, their eligibility will be made retroactive to that date and the member will be covered by the Alliance for the entire period. The member would not be considered “newly eligible.” If the member allows his or her benefits to lapse for more than 60 days from their annual renewal date, he/she would be considered newly eligible upon re-enrollment, with any period of retroactive eligibility covered by FFS Medi-Cal.

Providers should always verify eligibility prior to rendering services, to ensure eligibility and find out if coverage is through FFS Medi-Cal or the Alliance.

How to Verify Eligibility with the Alliance

Member eligibility verification is available online through the Provider Portal. If you have not used this feature in the past, you should complete the Provider Portal Account Request Form to register to use the Provider Portal. A link to the state Medi-Cal website is also accessible on our website in case you need to verify FFS Medi-Cal status.

The online and automated eligibility systems will provide you with the following information:

- Eligibility status for the date(s) of service requested.
- Name of the member’s PCP or notification that the member is an administrative member.
- Other health coverage the member may have (if applicable and if the Alliance is aware of coverage).
- The member’s eligibility for CCS (if applicable).
- A confirmation number.

Other ways to verify eligibility are:

- Call (800) 700-3874 ext.5501 for the 24-hour interactive voice-response eligibility verification line.
- Call the Alliance Member Services department at (800) 700-3874 (Mon–Fri, 8 a.m. - 5:30 p.m.). Eligibility can be verified for a maximum of three members at a time; please note that no confirmation number will be given.
When you telephone, please provide all of the following:

- The member’s full name.
- The member’s Alliance Member ID number or Social Security Number. If you do not have either of these, you must provide the member’s date of birth.
- Date(s) of service for which you want to check eligibility.

Please note that eligibility information is available for the current month and the preceding 11 months; we cannot check eligibility for dates of service past one year, nor can we verify eligibility for future dates of service. Remember that not all Medi-Cal beneficiaries will be Alliance members. If you cannot verify eligibility for a Medi-Cal member through the Alliance, swipe the Benefits Identification Card (BIC) or check the DHCS website; results should tell you if your patient is eligible for Medi-Cal but not covered under the Alliance. The Alliance is not able to verify eligibility for Medi-Cal beneficiaries who are not Alliance members.

If you are a PCP, you may also check your Alliance Member List through your Provider Portal account.

**Administrative vs. Linked Member**

A “linked” member of the Alliance is an individual who has selected or been assigned to a PCP. An “administrative member” is a member who is not assigned to a specific physician or clinic and, therefore, may see any willing Medi-Cal provider within the Alliance’s Service Area. Administrative members will have “Administrative Member” listed on their Alliance ID cards in the PCP section, rather than the name of a doctor or clinic. Newly eligible Alliance members will have “Administrative Member – Newly Eligible” on their ID cards in the PCP section. Categories of administrative members include:

- **Share of Cost** — A member who has Medi-Cal with a share of cost.
- **Long Term Care** — A member who is residing in a skilled or intermediate-care nursing facility for more than 30 days after the month of admission.
- **Out of Area** — A member who resides out of the Alliance’s service area but whose Medi-Cal case remains in Santa Cruz, Monterey or Merced counties. These may include out-of-area foster-care or adoption-assistance placements and long term care placements. They would also include members who have moved out of area and are in the process of having their Medi-Cal case transferred to their new county.
- **Newly Eligible** — A member in the first month of eligibility as an Alliance member who may see any willing Medi-Cal provider within the Alliance’s service area until they have chosen or been assigned to a PCP.
- **Other Health Coverage (OHC)** — A member who has other health insurance that is primary to their Medi-Cal; this includes members with both Medi-Cal and Medicare, as well as members with both Medi-Cal and commercial insurance. Alliance members with other health coverage must access care through their primary insurance. Except for dual eligibles (members with Medicare and Medi-Cal), an Alliance member with OHC does not become an administrative member until after the Alliance has verified their other health coverage.

The change of a member’s status from linked to administrative is not automatic — the Alliance must be informed of the member’s circumstances by the provider or the member in order to make the change in status. If you feel a member’s status should be changed to administrative for medical reasons you may submit a [Request for Administrative Member Status form](#). You may also contact our Health Services Department at (800) 700-3874 ext. 5512.
If you have information that an Alliance member has other health coverage (OHC) not reflected in the Alliance’s system, please provide the information on the OHC using the Provider OHC Referral Form on the Finance section of the Form Library page of the Alliance provider website. You may also submit the Explanation of Benefits from the primary payer along with your claim when you bill the Alliance as secondary.

For other non-medical reasons for a change in member status, please contact the Member Services Department at (800) 700-3874.

Claims for services rendered to administrative members must be sent to the Alliance. If the member has other health coverage, in addition to Medi-Cal, the claim should be sent first to the primary payer. All covered services that the Alliance is responsible for that are provided to administrative members are reimbursed by the Alliance on a fee-for-service basis.

For more information about administrative members, please see Policy 200-5000 - Administrative Member Status for Medi-Cal Members.

Member ID Card

The state of California issues a plastic Medi-Cal ID card known as the Benefits Identification Card, or BIC. The BIC shows the member’s name, date of birth, 14-digit identification number and the card issue date. Use this information to verify eligibility with the state or with the Alliance (the Alliance uses the first nine digits of the Medi-Cal ID number as the Alliance Member ID number). The county Social Services Department may issue a temporary, emergency “paper card” when the member cannot wait for the state to issue the BIC.

The Alliance also issues an ID card to members, an example of which is shown below.

The Alliance ID card is a black and white card that identifies Medi-Cal recipients as Alliance members; however, this ID card is not a guarantee of eligibility or payment for services. It is the responsibility of the provider to verify eligibility before providing services. Both eligibility and PCP linkage are subject to change. The provider is responsible for verifying eligibility for each date of service in which services are rendered. The Alliance member ID number has nine digits, starting with the number “9” and ending with a letter. Use this number to verify eligibility with the Alliance.

Alliance Medi-Cal members who are required to pay a share of cost (SOC) do not receive an Alliance ID card until they have met their SOC for the first time. Once a member meets his/her SOC for the first time, he/she will receive an Alliance ID card.
Out-of-Area Medi-Cal Beneficiaries

Medi-Cal beneficiaries who become eligible in counties other than Santa Cruz, Monterey or Merced are not the responsibility of the Alliance. However, any Medi-Cal provider may render services to these members and bill Affiliated Computer Services or the appropriate Medi-Cal Managed Health Care Plan.

When an Alliance member moves, the member must notify their County Medi-Cal benefits representative or, for those receiving Supplemental Security Income (SSI), notification is required to the Social Security Administration. Depending on when the move is reported, the member may be dropped from your case-management list by the first of the following month and will remain an administrative member until the member’s case is transferred to his/her new county.

If the Alliance member is CCS eligible, the Alliance will work with the County CCS program to transfer the CCS case to the new county of residence and coordinate appropriate care.

The majority of Alliance members who leave the service area will eventually become the financial responsibility of the new county of residence and cease to be Alliance members. The timeframe in which to effect this change depends on several factors and can take from 1-3 months. During this time, the member is covered by the Alliance only for emergency services while outside of the Alliance service area.

Circumstances in which a member moves or relocates out of our services area(s) that may not result in a change of the responsible county include: placement of foster care, adoption assistance for children out of our service area(s) or other out-of-area placement of children or residents who reside in long-term care facilities when there is a local conservator or guardian involved.

Alliance Care In-Home Supportive Services Program – Monterey County

Eligibility is determined by the Monterey County In-Home Supportive Service Program (IHSS) Public Authority and the Public Authority handles enrollment and premium collection. To be eligible for enrollment, a person must meet all of the following requirements:

- Work at least the minimum number of months and hours per month as established by the In-Home Supportive Services Public Authority of Monterey County, also referred to as the Public Authority.
- Live or work in Monterey County.
- Not have previously been terminated by the Alliance for fraud, deception or failing to provide complete information.
- Have submitted the required enrollment information to the Public Authority; and
- Applied at the time the Public Authority has openings to add subscribers to the Alliance Care IHSS Health Plan.

The Public Authority informs individuals when they are eligible to enroll in the Alliance Care IHSS Health Plan. After notification of eligibility, individuals may enroll themselves by submitting an enrollment application to the Public Authority at 1000 S. Main Street, Suite 211C, Salinas, CA 93901 within 30 days of notification of eligibility.
Please contact the Public Authority at (831) 755-4466 for more information about eligibility, enrollment, premiums and the start of coverage.

Provider Linkage
All Alliance Care IHSS members are linked to a PCP from their first day of eligibility. They select their PCP during the enrollment process. Members may change their PCP by contacting Member Services at (800) 700-3874. The change will be effective the first of the following month.

Alliance Care IHSS Member ID Card
The member ID card for our IHSS program has a strip of red across the top and the Alliance logo in the top right hand corner.
Medi-Cal and Alliance Care IHSS

To ensure that medically necessary, in-progress, covered medical services are not interrupted due to the termination of a provider’s contract; we assure continuity of care for our members, as well as for those newly enrolled individuals who have been receiving covered services from a non-participating provider.

When a provider’s contract is terminated or discontinued for reasons other than a medical disciplinary cause, fraud or other unethical activity, a member may be able to receive continued care with him/her after the contract ends. Continuity of care is permitted for the following conditions:

- An acute condition.
- A serious chronic condition and/or a terminal illness.
- A pregnancy and care of a newborn child from birth to 36 months.
- Surgery or other procedure that has been authorized and documented by the provider to occur within 180 days of the contract termination.
- Any other covered service dictated by good professional practice.
- The practitioner must continue to treat the member and must accept the payment and/or other terms.
- For an acute or terminal condition, the services shall be covered for the duration of the illness.
- For CCS eligible conditions under the Whole Child Model.
- For members receiving covered outpatient Behavioral Health and Behavioral Health Treatment Services.

For further details on continuity of care, please see Policy 404-1114 - Continuity of Care.
Section 6
Alliance Covered Benefits and Services

Covered Benefits

Medi-Cal
To view a summary of benefits for Alliance Medi-Cal members, please visit the Alliance member website.

Alliance Care IHSS Benefits
All health care services under the Alliance Care IHSS plan must be obtained from a participating Alliance provider, and all benefits are subject to the guidelines and procedures of our Utilization Management Department. The benefit year for Alliance Care IHSS is July 1 to June 30. There is a $3,000 copayment maximum per member per benefit year. To view a summary of benefits and copayments for Alliance Care IHSS members, please visit the Alliance member website.

Covered Services

Community Based Adult Services (Formerly Adult Day Health Care)
The Fee-for-Service (FFS) Medi-Cal benefit known as Adult Day Health Care ended in California on March 31, 2012. On April 1, 2012, the California Department of Health Care Services (DHCS) created a new benefit called Community Based Adult Services (CBAS). Effective, July 1, 2012, CBAS transitioned from a FFS Medi-Cal benefit to a managed care benefit, effectively administered through the Alliance.

There are four licensed CBAS centers that represent the three counties serviced by the Alliance. The Alliance is contracted with all four, providing effective coverage in Santa Cruz, Monterey, and Merced counties.

Licensed CBAS centers offer the following services to qualifying members:

- Professional nursing services
- Nutrition
- Physical Therapy
- Occupational Therapy
- Speech and language pathology services
- Transportation to and from the CBAS center, if required.

To qualify for CBAS services, members must be over the age of 18 and meet one of the following criteria:

- Meet “Nursing Facility Level of Care A” (NF-A) or above and meet “ADHC Eligibility and Medical Necessity criteria”; or
- Have a moderate or severe cognitive impairment, including moderate to severe Alzheimer’s Disease or other dementia comparable to, Stages 5, 6, or 7 Alzheimer’s disease and meet “ADHC Eligibility and Medical Necessity criteria”; or
- Have a developmental disability and meet “ADHC Eligibility and Medical Necessity criteria”; or
- Have a mild to moderate cognitive disability, including Alzheimer’s or dementia (comparable to stage 4 Alzheimer’s disease), and meet “ADHC Eligibility and Medical Necessity criteria”, and demonstrates need for assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
- Have a chronic mental illness and/or a brain injury, and meet ADHC eligibility and medical necessity criteria and demonstrate need for assistance or supervision with either:
  - Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
  - One need from the above list and one of the following: money management, accessing resources, meal preparation, or transportation.

Referrals for CBAS services may be made by a physician, community service agency, hospital or health care provider, or a CBAS center.

Prior authorization through the Alliance is required to obtain CBAS services. A face-to-face assessment by an Alliance registered nurse will be done prior to an assessment being started at the CBAS center. The authorization process entails eligibility screening, a multidisciplinary assessment at the CBAS center, completion of an Individualized Plan of Care (IPC) by the CBAS center, and decision-making by the Alliance. If approved after the Alliance assessment, the members may receive CBAS services from one to five days per week, depending upon the member’s acuity and unique needs. Reauthorization is required every six months by submitting an Authorization Request to the Utilization Management Department, along with any necessary medical documentation for review.

For more information on CBAS, please see Policy 405-1111 - Community Based Adult Services and Enhanced Case Management.

**eConsult Program**

The Alliance offers contracted primary care physicians (PCPs), Physician Assistants (PAs) and Nurse Practitioners (NPs) providing primary care access to specialist networks via eConsult services. eConsult utilizes a HIPAA secure web-based platform to enable communication between a provider and a specialist. eConsult typically presents a brief question regarding a patient’s symptom management or diagnosis and may include medical records and images. Like email, communication occurs asynchronously, but includes follow up questions and clarifications.

**Program Eligibility**

PCPs that are contracted and linked to Alliance Medi-Cal members may participate in this program. In addition, PAs and NPs that meet these same requirements, and are supervised by a PCP who participates in the program, are eligible.
Requirements of Participating Providers

All participating providers must agree to vendors’ terms of service and utilize eConsult services exclusively for Alliance primary Medi-Cal members without other health care coverage. Supervising PCPs will oversee all cases submitted by PAs or NPs.

Note that the PCP remains solely responsible for the diagnosis and treatment of his or her patients. If a PCP is unsure of the course of action following use of eConsult, they are still obligated to deliver the appropriate standard of care through the established referral process.

eConsult Partners

The Alliance contracts with three vendors that offer eConsult services and PCPs may work with any of these organizations. Interested providers should contact the vendors directly to determine which organization best meets their needs. The vendors will provide training on how to use their platform and consult with specialists.

Alliance approved eConsult vendors and contact information is listed below:

AristaMD
www.aristamd.com
Brooke LeVasseur, Chief Executive Officer
brooke@aristamd.com
(415) 254-2672

Direct Dermatology
www.directderm.com
Eliana Gonzalez, Provider Relations
eliana.gonzalez@directderm.com
(916) 599-1140

RubiconMD
rubiconmd.com
Swati Kumar, Senior Implementation Manager
swati@rubiconmd.com
(248) 825-7616

To become a referring specialist, physicians can contact Alliance eConsult vendors directly.

Urgent Visit Access

Urgent Visit Access offers an alternative access site for an urgent visit if the member’s PCP is not able to accommodate an acute visit.

Participating Urgent Visits Access Site Requirements

Many Alliance PCPs are open evenings and weekends. In order to participate as an Urgent Visit Access participating provider, PCPs would:

- Provide urgent visits to non-linked Alliance members and
Section 6. Alliance Covered Benefits and Services

- Be open an extended hour each weekday, beyond the typical Monday – Friday, 8 a.m. to 5 p.m. or
- Be open for a minimum of four (4) hours on the weekends

The Alliance may make exceptions to these criteria on a case-by-case basis.

**Member Steps**

If a member needs care after regular office hours, they can take the following steps:

1. Call their PCP and ask if an appointment is available.
2. Call the Nurse Advice Line (NAL) for an over-the-phone assessment and guidance of what to do next.
3. If the member’s PCP is unable to accommodate an urgent visit or by the recommendation of the NAL, the member may seek care at a participating Urgent Visit Access site. No referral is required.

**Documentation**

Urgent Visit Access sites have been asked to fax information to the member’s PCP with details of the visit. This may be an after-visit summary or a full clinic note (preferred).

**Referrals**

Referrals required subsequent to the urgent visit will be directed to the PCP. If an urgent specialist referral is needed, a call should be made from the participating urgent visit site to the PCP to facilitate an immediate referral.

For more information on how to become a participating Urgent Visit Access site, please contact your Provider Relations Representative at: (800) 700-3874, ext. 5504.

**Emergency Services**

Emergency services are covered inpatient and outpatient services that are necessary to enable stabilization or evaluation of an emergency medical condition and are provided by a health care professional qualified to furnish emergency services.

An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the individual or, in case of a pregnant woman, the health of the woman or her unborn child.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

*No prior authorization is required for emergency/urgent services and emergency hospital admissions.* All inpatient hospital stays require an authorization after admission. Authorization can be obtained by faxing a Hospital Admission Face Sheet and clinical documentation to the Utilization Management Department to (831) 430-5850.
For emergency hospital admissions and emergency room outpatient services, the hospital should verify the member’s eligibility and assigned PCP by telephoning our Eligibility Verification System or Eligibility Clerk. Contracting facilities are obligated to notify the Alliance within one business day of service and to forward a copy of the ED report/face sheet to the PCP within the same timeframe.

When a member presents an emergency condition at a hospital or other provider facility and is admitted for inpatient services, the hospital/treating physician should notify the PCP and the Alliance within one working day of admission.

For more information on hospital services, see section below.

Providers may direct their Alliance Medi-Cal patients to any outpatient clinical laboratory that services Alliance Medi-Cal members. Alliance Care IHSS and Medi-Cal Access Program members should be directed to any contracted outpatient clinical laboratory. An updated list of contracted laboratories is available in the Provider Directory.

**Hospital Services**

**NICU Services for CCS-Eligible Members**

The Alliance will authorize CCS-eligible NICU stays based on the CCS policy for Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit. Authorization will only be provided for the level of services for which a NICU has been approved by DHCS. If the NICU is not CCS-approved, or if the level of care that is required by the member is above the NICU level of approval, the hospital must follow CCS guidelines for Stabilization, Transfer and Transport of a CCS-Eligible NICU Patient.

**Medical Records**

Each hospital is responsible for maintaining adequate medical records of patient care. Records should be maintained in accordance with applicable state and federal privacy laws. The Alliance has the right to review records for claims authorization and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards as well as all federal, state and accrediting body regulations. For more information, see Policy 401-1510 - Medical Record Review and Requirements.

**Discharge Planning**

Discharge planning is initiated upon admission to facilitate the transition of beneficiaries to the next phase of care. The discharge planning team is multi-disciplinary and consists of treating physician and hospital discharge planners. Physician responsibility includes participation in coordinating member discharge planning and referrals to appropriate post-discharge settings. Alliance staff will work with the hospital’s discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

**Acute Administrative Days – Medi-Cal Only**

Acute administrative days are those days approved in an acute care inpatient facility which provides a higher level of medical care than that currently needed by the patient. These days may be authorized for patients awaiting placement in skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). For more
information on how hospitals may qualify for reimbursement of acute administrative days, please see Policy 404-1520 - Administrative Day Criteria.

Identification and Referral of CCS Cases

Admitting physicians, hospital discharge planners, neonatologists, hospital pediatricians and other hospital staff, as appropriate, shall work with the Alliance to ensure that children with potentially CCS-eligible conditions are identified and referred to the local county CCS program for CCS eligibility determination. For more information on CCS referral procedures, please see Policy 404-1305 - Screening and Referral of Medically Eligible Children to CCS Program. Please refer to California Department of Health Care Services (DHCS) website for more information regarding California Children’s Services (CCS).

Authorizations

For more detailed information about the hospital authorization process, please see the policies linked below:

- Policy 404-1102 – Inpatient Review
- Policy 404-1201 – Authorization Request Process
- Policy 404-1521 - Hospital Stays Where Discharge, Death or Transfer Occurs on the Day of Admission
- Policy 404-1524 - Long Term Care for Medi-Cal Members
- Policy 404-1525 - Skilled Nursing Facility Program Policy For Medi-Cal

Utilization Management

For detailed information on the Alliance Utilization Management Program, please see Policy 404-1101 - Utilization Management Program.

Credit Balance Report

The Alliance requires all participating contracted Hospital Providers to complete a Credit Balance Report on a quarterly basis. The report is used to monitor, identify, and recover “credit balances” owed to the Alliance for improper or excess payments made to the provider resulting from claims processing errors. For detailed information on completing and submitting the Credit Balance Report, please see Policy 702-1300 – Credit Balance Report.

Laboratory Services

The Alliance reimburses contracted physicians for certain Clinical Laboratory Improvement Amendments (CLIA) waived lab tests that are performed in a physician’s office, if the physician meets the requirements of 42 USC Section 263a (CLIA) and provides the Alliance with a current CLIA Certificate of Waiver. Effective in 2015, the Alliance has expanded the list of approved CLIA waived labs to include those allowed by Medi-Cal. More information on the codes can be found in the Pathology: Billing and Modifiers section of the Medi-Cal Provider Manuals. If a code is not located in the table below, providers should review the Medi-Cal Provider Manuals to confirm the code is allowed by Medi-Cal as a CLIA waived lab.
### CLIA Waived Lab Tests*

<table>
<thead>
<tr>
<th>Code</th>
<th>Test Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80048</td>
<td>Basic metabolic panel (calcium, total)</td>
</tr>
<tr>
<td>80053</td>
<td>Comprehensive metabolic panel</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis by dipstick; automated w/o microscopy</td>
</tr>
<tr>
<td>82565</td>
<td>Creatinine; blood</td>
</tr>
<tr>
<td>83036</td>
<td>Hemoglobin; glycosylated (A1c)</td>
</tr>
<tr>
<td>83655</td>
<td>Lead</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid stimulating hormone (TSH)</td>
</tr>
</tbody>
</table>

*TB testing is Alliance approved, but is not a CLIA waived lab. Please use CPT code 86580 – Skin test; Tuberculosis, Intradermal New Technology Assessment.

Upon request for information, following Policy 404-1714 - Technology Assessment, the Alliance will evaluate new technologies such as medical and behavioral health procedures, pharmaceuticals and devices, and will evaluate changes in the application of existing technologies to determine whether a new technology should be an added benefit.

### Skilled Nursing Facilities and, Long Term Care, and Private Duty Nursing Medi-Cal

Long Term Care (LTC) is defined as care in a facility for longer than one full month. LTC facilities may include a Skilled Nursing Facility (SNF), sub-acute facilities (pediatric and adult) or intermediate care facilities.

Determination of the most appropriate level of care for the member, and the best facility to provide such care, is made by collaborative efforts between the PCP, the hospital Discharge Planning/Care Management departments, and the Alliance Utilization Management and Case Management teams. Prior authorization is required for approval of admission to a long term care facility of any kind.

The criteria for receiving skilled-nursing services must meet the level-of-care standards set by Medi-Cal (Title 22, Section 51215).

- The patient must require the continuous availability of procedures, including but not limited to: Administration of IV, IM or SC injections and IV or SC infusions.
- Gastric tube or gastronomy feedings.
- Nasopharyngeal aspiration.
- Insertion or replacement of catheters.
- Application of dressings involving prescribed medications and aseptic techniques.
- Treatments that require observation by licensed health care staff to evaluate the patient’s progress.
- Administration of medical gases under a prescribed therapeutic regimen.
- Restorative nursing procedures that require the presence of a licensed nurse. Medically necessary long term care will be authorized by the Alliance at the time of admission for
members who meet the criteria. If the member does not meet the criteria for long term care, if no AR was submitted, or if the facility is unable to meet the member’s nursing needs, a denial notice will be sent to the member, the PCP and the admitting physician. The notification will include the process to appeal the denial decision.

Unless otherwise determined, the PCP and member relationship continues during the limited long term care stay.

For more information on LTC and SNF benefits for Alliance Medi-Cal members, please see policies:
404-1524 - Long Term Care for Medi-Cal Members.
404-1525 - Skilled Nursing Program Policy for Medi-Cal

Medi-Cal Long Term Care Facility Admission and Discharge Notification (MC171) Form
Medi-Cal LTC Facilities are required to complete the Medi-Cal Long Term Care Facility Admission and Discharge Notification Form (MC171) on the day of admission or discharge of the patient. The MC171 form is located on the DHCS website.

On admission to an LTC facility, a Medi-Cal recipient or the recipient’s representative must complete the Medi-Cal Long Term Care Facility Admission and Discharge Notification (MC171) form, Parts I and II.

When a Supplemental Security Income (SSI) recipient enters a LTC facility, providers must notify a Social Security Administration (SSA) field office of the recipient’s name, Social Security Number (SSN) and date of entry. SSI recipients are required to report their status to the provider when entering a nursing facility.

- The LTC facility must retain a copy of the MC171 form for its files and send either the original or a copy to the proper government agencies depending on whether:
  - The patient receives Supplemental Security Income/State Supplemental Payment (SSI/SSP);
  - The patient receives aid under any program other than SSI/SSP.

- If the patient receives SSI/SSP, the original MC171 should be sent to the local Social Security Office. The aid code for these recipients is 10, 20, or 60. A copy of the MC 171 should also be forwarded to the local county welfare department.

- If the patient receives aid under a program other than SSI/SSP; the original MC171 should be sent to the local county welfare department. The aid code for these recipients will be other than 10, 20, or 60.

- The LTC facility is not required to submit a copy of the MC171 form to the California Department of Health Care Services, Medi-Cal Eligibility Division. The Medi-Cal field office will use the recipient’s initial Treatment Authorization Request (TAR) as notification of the patient’s admission.

- When the patient is discharged (or expires), the facility must complete Part III of the MC171 form and submit the original copy to the county welfare department. For additional information,
private duty nursing is an epsdt supplemental services benefit (for individuals under age 21). for additional information, please see policy 404-1720 private duty nursing epsdt benefit.

alliance care ihss

for alliance care ihss members, prior authorization is required for approval of admission to a snf of any kind. determination of the most appropriate level of care for the member, and the best facility to provide such care, is made by collaborative efforts between the pcp, the hospital discharge planning/care management departments, and the alliance utilization management and case management teams. to qualify for skilled-nursing care, the patient must require the continuous availability of procedures, including but not limited to:

- administration of iv, im or sc injections and iv or sc infusions.
- gastric tube or gastronomy feedings.
- nasopharyngeal aspiration.
- insertion or replacement of catheters.
- application of dressings involving prescribed medications and aseptic techniques.
- treatments that require observation by licensed health care staff to evaluate the patient’s progress.
- administration of medical gases under a prescribed therapeutic regimen.
- restorative nursing procedures that require the presence of a licensed nurse.

medically necessary skilled-nursing care will be authorized by the alliance at the time of admission for members who meet the criteria. if the member does not meet the criteria for a snf, if no ar was submitted or if the snf is unable to meet the member’s skilled nursing needs, a denial notice will be sent to the member, the pcp and the admitting physician. the notification will include the process to appeal the denial decision.

telehealth

telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. (section 2290.5(a)(6) of the business and professions code).

telehealth coverage

in keeping with current california law (ab 415 passed in 2011), the alliance provides coverage for telehealth services, as defined above. this service is intended specifically to provide access to specialty services that
would otherwise have limited availability. Services may be delivered as asynchronous store and forward or synchronous interaction.

**Synchronous Telehealth Services and Settings**
Synchronous telehealth is real-time interaction between a member and a health care provider located at a distant site. The member’s provider may be present at the originating site during synchronous interaction if deemed necessary. Synchronous telehealth services can be provided to Alliance members by any Alliance credentialed health care provider with the member’s verbal consent, as documented in the patient’s medical record.

**Asynchronous Telehealth Services and Settings**
Asynchronous telehealth is the transmission of a member’s medical information, including photographs, x-rays, or other forms of data, from an originating site to the health care provider at a distant site without the presence of the member. Asynchronous store and forward telehealth services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time. The following health care providers may provide store and forward services:

- Ophthalmologists.
- Dermatologists.
- Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code).

The Alliance will pay for services in teledermatology, teleoptometry and teleophthalmology, as long as they meet federal and state guidelines for medical necessity and are covered benefits according to the Alliance member’s Evidence of Coverage (EOC). Services provided by telehealth may require a referral from the PCP. Providers should follow the procedures outlined in Policy 404-1303 - Referral Consultation Request Process.

Patients receiving teledermatology, teleophthalmology or teleoptometry services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the patient’s notification of the results of the consultation.

Telehealth services are also available for mild to moderate mental health services. See section 7: Carved Out Services: Medi-Cal for more information.

Telehealth services can be provided in a number of settings: physician office, clinic, hospital, skilled nursing facility, or a member’s home. These would each be considered originating sites. A licensed provider must be present if the provider fee for the visit is to be reimbursable. If a licensed provider is not present at the originating site, a site facility fee may be billed in lieu of the provider fee for the visit. In addition, transmission cost fees may be billed. For lines of business that require a copay for services, the payment will be collected at the time of the member’s visit to the originating site.

At the distant site expert providers would serve as consultants or offer ongoing care for specific conditions. That provider may bill for an office or inpatient consultation as well as transmission cost fees. For those lines
of business that require a copay for services, the payment will be waived for services provided at the distant site.

The health care provider at the originating site must inform the member that telehealth services will be used and obtain the member’s verbal or written consent, which will be documented in the member’s medical record. In situations when the asynchronous store and forward system is used, members must be notified of their right to have interactive communication with the distant specialist at the time of the consultation or within 30 days of the patient’s notification of the results of the consultation. In all circumstances, providers will abide by HIPAA laws, including not disclosing a member’s personal health information to any third party without written consent.

The audio-video telemedicine system used, must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT-code billed.

**Billing Guidelines**

Below are guidelines for providers using telehealth services to enable providers to accurately bill for such services. The Alliance will reimburse contracted providers for telehealth services as described in Alliance Policy 404-1727 – Provision of Telehealth Services.

**Reimbursement for Telehealth Services**

The three main models of telehealth services available to Alliance members are explained on the following pages.

**Reimbursement for Traditional Synchronous Telehealth Services**

<table>
<thead>
<tr>
<th>Originating Site</th>
<th>Distant Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient present</td>
<td>• Provider of service</td>
</tr>
<tr>
<td>• Provider optional</td>
<td></td>
</tr>
</tbody>
</table>

**Billing guidelines for originating site providers:**

<table>
<thead>
<tr>
<th>Originating Site</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Code</td>
</tr>
<tr>
<td>Site facility fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Cost</td>
<td>T1014 (per minute for maximum of 90 min. per patient)</td>
</tr>
<tr>
<td>Licensed provider fee <em>(if present)</em></td>
<td>E&amp;M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.</td>
</tr>
</tbody>
</table>
If a licensed provider also is present at the telehealth originating site with the patient present and a progress note is generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating provider should be documented in the progress note that are distinct from those provided by the distant site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed. No modifier is needed at the originating site. For lines of business requiring a copay for services, the payment will be collected at the originating site.

** Billing guidelines for distant site providers: **

<table>
<thead>
<tr>
<th>Distant Site</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission Cost</td>
<td>T1014 (per minute for maximum of 90 min. per patient)</td>
</tr>
<tr>
<td>Initial hospital care or subsequent hospital care (new or established patient)</td>
<td>99221 – 99233</td>
</tr>
<tr>
<td>Licensed Provider Fee</td>
<td>99201 – 99215</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient (initial or follow-up), Inpatient, and confirmatory</td>
<td>99241 – 99255</td>
</tr>
<tr>
<td>Required Modifier</td>
<td>GT modifier required for all CPT-Codes except Transmission Cost codes</td>
</tr>
</tbody>
</table>

For those lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

** Reimbursement for Asynchronous Telehealth Services (Store and Forward) for Teleophthamology, Teleoptometry and Teledermatology Services:**

** Originating Site **
- Patient present
- Provider optional

** Information stored and forwarded to Distant Site **

** Distant Site **
- Provider of service

** Billing guidelines for originating site providers: **

<table>
<thead>
<tr>
<th>Originating Site</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Code</td>
</tr>
<tr>
<td>Site facility fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Cost</td>
<td>T1014 (per minute for maximum of 90 min. per patient)</td>
</tr>
<tr>
<td>Licensed provider fee (if present)</td>
<td>E&amp;M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.</td>
</tr>
</tbody>
</table>
If a licensed provider also is present at the telehealth-originating site, with the patient present and a progress note generated by the originating provider, the visit is reimbursable as a visit. The scope of the interaction with the originating provider should be documented in the progress note, and will be the basis of the CPT code(s) used. If a CPT code is included, the originating site fee and the transmission cost fees may still be billed. No modifier is needed. For lines of business requiring a copay for services, the payment will be collected at the originating site.

**Billing guidelines for distant store and forward site providers:**

<table>
<thead>
<tr>
<th>Distant Store and Forward Site</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Provider Fee</td>
<td>92002, 92004, 92012, 92014, 99201-99215</td>
</tr>
<tr>
<td><strong>Office consultation</strong>, new or established patient</td>
<td>99241 - 99255</td>
</tr>
<tr>
<td>Retinal photography with interpretation for services provided by optometrists or ophthalmologists</td>
<td>92250</td>
</tr>
<tr>
<td>Required Modifier</td>
<td>All asynchronous, store-and-forward services are billed with a “GQ” modifier</td>
</tr>
</tbody>
</table>

For lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

**Reimbursement for Synchronous: Provider to Patient Telehealth Services**

The Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient’s home or other location. For lines of business requiring a copay, the payment will be collected at the originating site.

<table>
<thead>
<tr>
<th>Originating Site - Patient Location</th>
<th>Distant Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health facility</td>
<td>• Provider Site</td>
</tr>
<tr>
<td>• Residential home</td>
<td>• Patient NOT present</td>
</tr>
<tr>
<td>• Patient home</td>
<td></td>
</tr>
</tbody>
</table>

**Billing guidelines for the distant site:**

<table>
<thead>
<tr>
<th>Distant Site</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Code</td>
</tr>
<tr>
<td>Transmission Cost</td>
<td>T1014 (per minute for maximum of 90 min. per patient)</td>
</tr>
<tr>
<td>Licensed provider fee (if present)</td>
<td>E&amp;M codes 99201 – 99215</td>
</tr>
</tbody>
</table>
For lines of business that require a copay for services, the payment will be waived for services provided at the distant site.

A licensed provider, who provides E&M services for a patient utilizing telehealth technology to access the provider’s office, may submit claims for the service using the E&M code, without the modifier. The contracted arrangements for primary care providers and specialty providers continue to apply. T1014 Transmission Cost fee may also be billed.

**Exclusions**

Telehealth does not include email, telephone (voice only), text, inadequate resolution video or written communication between providers or between patients and providers.

**Palliative Care Services**

The Palliative Care benefit is designed to help members with advanced disease states to understand and receive supportive and specialized healthcare before hospice care is indicated. In its full capacity, the Palliative Care benefit will connect members with clinicians who are trained to focus on symptom management and who understand advance care planning and end of life complexities.

**Eligible Members**

Members eligible for the benefit are expected to have one (1) year or less life expectancy, be in the advanced stage of illness, have received appropriate patient-desired medical therapy, or for whom patient-desired medical therapy is no longer effective, and have started to access the hospital or emergency department as a means to manage late stage illness. Members should also have one or more of the following disease-specific eligibility criteria:

- Congestive heart failure (CHF): hospitalized due to CHF as primary diagnosis (no further invasive interventions planned) OR NYHA III or higher AND EF <30% or significant comorbidities
- Chronic obstructive pulmonary disease (COPD): FEV1<35% predicted and 24 hour and O2 requirement less than 3L/min OR 24 hour O2 requirement ≥3L/min
- Advanced cancer: any stage III or IV solid organ cancer, leukemia or lymphoma AND Karnofsky Performance Scale score < 70 OR treatment failure of 2 lines of chemotherapy
- Liver disease: evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND ascites, spontaneous bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices OR evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.
- Other advanced disease states will be considered on a case-by-case basis
**Eligible Providers**

Contracted rendering physician leaders of Palliative Care teams must 1) be credentialed under Primary Care Physician Services Agreement or a Referral Physician Services Agreement, and 2) meet the Palliative Care specific requirements set forth in Policy 404-1527 – Palliative Care.

**Eligible Services**

Palliative Care services include advanced care planning, palliative assessment and consultation with a palliative care team, care coordination, and mental health and medical social services for counseling and support. Pastoral care may also be provided, though it is not reimbursed by the Alliance. Traditional Palliative Care provision includes curative and/or supportive treatment planning, pain and symptom management, medication side effects, emotional and social challenges, spiritual concerns, patient goal setting, and advance directives, including completion of physician order for life-sustaining treatment (POLST) form.

Palliative Care services must receive prior authorization from the Alliance. To receive reimbursement for Palliative Care services, the provider must include the authorization number on the claim form, as well as a U1 modifier as described below. Claims for Palliative Care services will be processed in accordance with Alliance policies and procedures. If Palliative Care services are provided to members with OHC or Medicare, the services rendered must be billed to the primary insurance first. The claim should be then sent to the Alliance with the primary insurer’s explanation of benefits. All applicable coordination of benefit rules apply to claims for Palliative Care services.

The codes and frequency limits for Palliative Care services are listed below. Providers must include a U1 modifier in the first position for every code submitted for Palliative Care services on the claim.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202-99205</td>
<td>Office Or Other Outpatient Visit For The Evaluation And Management Of A New Patient</td>
<td>One time per 36 months per member</td>
</tr>
<tr>
<td>99212-99215</td>
<td>Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99241-99245</td>
<td>Office Consultation For A New Or Established Patient</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99304-99310</td>
<td>Initial Nursing Facility Care, Per Day, For The Evaluation And Management Of A Patient</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99324-99328</td>
<td>Domiciliary Or Rest Home Visit For The Evaluation And Management Of A New Patient</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99334-99337</td>
<td>Domiciliary Or Rest Home Visit For The Evaluation And Management Of An Established Patient</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99341-99345</td>
<td>Home Visit For The Evaluation And Management Of A New Patient</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency Limitations</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>99347-99350</td>
<td>Home Visit For The Evaluation And Management Of An Established Patient</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99354</td>
<td>Prolonged Evaluation And Management Or Psychotherapy Service(s) (Beyond The Typical Service Time Of The Primary Procedure) In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; First Hour</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99355</td>
<td>Prolonged Evaluation And Management Or Psychotherapy Service(s) (Beyond The Typical Service Time Of The Primary Procedure) In The Office Or Other Outpatient Setting Requiring Direct Patient Contact Beyond The Usual Service; Each Additional 30 Minutes</td>
<td>Four times per day per member</td>
</tr>
<tr>
<td>99356</td>
<td>Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; First Hour</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99357</td>
<td>Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; Each Additional 30 Minutes</td>
<td>Six times per day per member</td>
</tr>
<tr>
<td>99358-99359</td>
<td>Prolonged Evaluation And Management Service Before And/Or After Direct Patient Care; First Hour</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99487</td>
<td>Complex Chronic Care Management Services, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions Expected To Last At Least 12 Months, Or Until The Death Of The Patient; Chronic Conditions Place The Patient At Significant Risk</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99489</td>
<td>Complex Chronic Care Management Services, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions Expected To Last At Least 12 Months, Or Until The Death Of The Patient; Chronic Conditions Place The Patient At Significant Risk</td>
<td>One time per day per member</td>
</tr>
<tr>
<td>99490</td>
<td>Chronic Care Management Services, At Least 20 Minutes Of Clinical Staff Time Directed By A Physician Or Other Qualified Health Care Professional, Per Calendar Month, With The Following Required Elements: Multiple (Two Or More) Chronic Conditions</td>
<td>No frequency limitation</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency Limitations</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>99497</td>
<td>Advance Care Planning Including The Explanation And Discussion Of Advance Directives Such As Standard Forms (With Completion Of Such Forms, When Performed), By The Physician Or Other Qualified Health Care Professional; First 30 Minutes, Face-To-Face</td>
<td>One time per day up to two times per month per member</td>
</tr>
<tr>
<td>99498</td>
<td>Advance Care Planning Including The Explanation And Discussion Of Advance Directives Such As Standard Forms (With Completion Of Such Forms, When Performed), By The Physician Or Other Qualified Health Care Professional; Each Additional 30 Minutes</td>
<td>One time per day up to two times per month per member</td>
</tr>
<tr>
<td>G0505</td>
<td>Cognition And Functional Assessment Using Standardized Instruments With Development Of Recorded Care Plan For The Patient With Cognitive Impairment, History Obtained From Patient And/or Caregiver, In Office Or Other Outpatient Setting Or Home Or Domi...</td>
<td>One time per three months per member</td>
</tr>
<tr>
<td>G0506</td>
<td>Comprehensive Assessment Of And Care Planning For Patients Requiring Chronic Care Management Services (List Separately In Addition To Primary Monthly Care Management Service)</td>
<td>One time per member at onset of chronic care management services</td>
</tr>
</tbody>
</table>

For the purpose of calculating frequency limitations, a new patient shall be defined as someone who has not been seen in the preceding three years by a practitioner or provider in the same specialty as the practitioner or provider who is rendering care.

For more information, please see Policy 404-1527 - Palliative Care.

**Transportation: Emergency and Non-Emergency**

**Emergency Transportation from PCP Office to Hospital**

On occasion members require admission to acute-care facilities directly from the PCP’s office; in such cases we reimburse the costs of this transportation to the hospital.

When a PCP determines that a member requires immediate hospitalization from his or her office, the PCP may determine at his/her own medical discretion which is the most appropriate and safe mode of transportation.

If the PCP has determined that taxicab service is more appropriate than ambulance service, they must notify the Health Services Transportation & Linguistic Coordinator after the taxicab has been called to ensure...
reimbursement to the taxicab company. The Coordinator can be reached at (800) 700-3874 ext.5577. The Coordinator will document in the PCP’s notification that a taxicab was called to transport the member to the hospital.

For more information about emergency transportation, please see Policy 404-1724 - Hospital Transportation from PCP Office.

**Non-Emergency Medical Transportation: Medi-Cal**

The Alliance covers Non-Emergency Medical Transportation (NEMT) as specified in the California Code of Regulations, Title 22, Section 51323. Such transportation is approved when the member has a medical condition that prevents him or her from traveling by another form of conveyance without jeopardizing the member’s health.

NEMT will be authorized for the transfer of a member from a hospital to another hospital or facility provided that the transport is medically necessary, has been requested by an Alliance provider, and has been authorized in advance by the Alliance. We require advance notice of five days for all NEMT requests. Specifically, the following types of transport will be allowed:

- The member is being moved either to a higher or lower level of care. Please note that the transfer from one level of care to the same level of care at another facility will not be authorized if the requesting facility is able to meet the member’s medical needs.
- The member requires transportation from his/her home to a medically necessary medical appointment for services covered by the Alliance.

The Alliance does not cover NEMT when a member is going from a facility to his or her home, unless the member is receiving hospice services.

The Alliance does not cover public transportation such as airplane, passenger car, taxicab or other forms of public conveyance. Selection of an appropriate transportation service will take the following into account:

- Member’s medical and physical condition.
- Urgency of the need for transportation.
- Availability of transportation at the time of need.

If a member disputes a determination that he/she does not meet the criteria for coverage of NEMT, the Transportation Coordinator will review the transportation request for Non-Medical Transportation (NMT) criteria or for other options.

Please contact the Transportation Coordinator at 831-430-5577 or (800) 700-3874 ext.5577.

For more information on NEMT, please see Policy 404-1726 - Non-Emergency Medical Transportation.

**Non-emergency Transportation: Alliance Care IHSS**

Non-emergency transportation will be authorized for the transfer of Alliance Care IHSS members from a hospital to another hospital or facility provided that the transport is medically necessary.

Please contact the Transportation Coordinator at (800) 700-3874 ext.5577.
For more information on non-emergency transportation, please see Policy 404-1726 - Non-Emergency Medical Transportation.

**Non-Medical Transportation: Medi-Cal Only**

Non-Medical Transportation (NMT) services are available for Alliance Medi-Cal members. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members; this is currently available under the NEMT benefit.

Physicians may authorize NMT for members currently using a wheelchair only if the member is able to ambulate without assistance from the driver. If assistance is required, the transportation would be arranged through NEMT. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.

**Eligibility requirements:**

- Members must be eligible at the time of service.
- Member must attest (in-person, electronically, or over the phone) that all other transportation resources have been reasonably exhausted.
- Prior authorization is required.
  - Transportation must be requested 5-7 business days in advance of the trip to ensure time to process the authorization and coordinate transportation.
- Transportation must be for an Alliance covered service or Medi-Cal service that is not covered under the Central California Alliance Health Managed Care Plan contract. This includes doctor’s appointments, pharmacy, or to pick up medical equipment or supplies.
- The transportation provided must be the least costly method of transportation that meets the member’s needs.

NMT transportation may be by public transportation, passenger car, taxicab, or any other form of public or private conveyance. The type of transportation authorized to members will depend on their circumstances and the lowest cost type of transportation available.

Mileage reimbursement will be based on IRS Standard mileage rate for Medical Purposes.

- The driver must be compliant with all California driving requirements.
- The driver cannot be the member.
- Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available.

NMT services help must be requested at least 5-7 business days in advance for initial services or routine visits. More time may be necessary for more complex requests. All requests should be submitted to Alliance Transportation Coordinators at 1-800-700-3874 ext. 5577.

For more information on Non-Medical Transportation, please see Policy 404-1725 - Non-Medical Transportation.
For more information on the Meals, Transportation, and Lodging benefit for CCS-eligible members, please see Policy 404-1732 - Maintenance and Transportation for Members with CCS Eligibility.
Section 7
Carved Out and Subcontracted Benefits and Services

Carved Out Services: Medi-Cal

Certain medical or allied-health services are not included in the Alliance’s benefits package and thus we are not responsible for authorizing or providing those services; rather, they are covered directly by the state Medi-Cal program. These are referred to as “Carved-Out Benefits.” Following is a list of these benefits with contact information.

Dental Services

Please call Denti-Cal at (800) 322-6384 for assistance in locating a Medi-Cal dentist or to obtain prior authorization for service.

Behavioral Health Services

Short-Doyle/Medi-Cal County Behavioral Health services (inpatient or outpatient)

Specialty Mental Health Services

Providers are required to provide assistance to Medi-Cal members needing Specialty Mental Health services for the Severely Mentally Ill (SMI) by calling the County Behavioral Health Access phone numbers in the table below.

Beacon Health Options does not provide Specialty Behavioral Health services, but can assist members with accessing county mental health services. Providers can reach Beacon by calling (855) 765-9700. Additionally, providers should coordinate services with the Medi-Cal member’s mental health provider, as appropriate.

<table>
<thead>
<tr>
<th>County Behavioral Health Access</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz County Behavioral Health Access</td>
<td>(800) 952-2335</td>
</tr>
<tr>
<td>Monterey County Behavioral Health Access</td>
<td>(888) 258-6029</td>
</tr>
<tr>
<td>Merced County Behavioral Health Access</td>
<td>(888) 334-0163</td>
</tr>
</tbody>
</table>

- Alcohol and Drug Treatment program services (including Voluntary Inpatient Detoxification and outpatient heroin detoxification).
  - PCPs are required to provide assistance to Medi-Cal members needing Alcohol and Drug Treatment services by referring them to the appropriate county or community agency. The phone numbers for the County Behavioral Health Access teams are in the table above. PCPs may call...
Beacon Health Options for assistance in appropriately referring members with Substance Use Disorders. Providers can reach Beacon by calling (855) 765-9700.

Physicians credentialed under a Primary Care Physician Services Agreement and with a DEA X license may provide Medication Assisted Treatment (MAT) for substance use disorders and to prevent opioid overdose.

**Laboratory Services**

Laboratory services are provided under the state serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of DHCS.

**Other Carved Out Services**

Targeted Case Management Services as specified in Title 22 CCR Section 51351.

Certain home and community-based wavered services (e.g., In Home Operations, HIV/AIDS Home and Community Based Services Waiver, Multipurpose Senior Services Program) are available through Medi-Cal waiver programs administered by DHCS or community-based organizations. For more information on waiver services please see Policy [405-1107 - HIV-AIDS Home and Community Based Services Waiver Programs](#) and Policy [405-1108 - Medi-Cal Home and Community Based Services (HCBS) Waiver Programs](#).

**California Children’s Services – Medical Therapy Program**

The Medical Therapy Program (MTP) is a special program within California Children’s Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

The MTP is administered by the County CCS program.

**Subcontracted Benefits**

**Behavioral Health Benefits: Medi-Cal**

Effective January 1, 2014 outpatient services for mild to moderate mental health conditions are a benefit covered by the Alliance. The Alliance covers specified services to adults and children diagnosed with a mental health disorder, as defined by the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in mild to moderate impairment of mental, emotional, or behavioral functioning. The Alliance partners with Beacon Health Options (Beacon)/College Health IPA (CHIPA), a Managed Behavioral Health Organization (MBHO), to administer behavioral health services on behalf of the Alliance. These services are provided through Beacon’s provider network. PCPs may refer members to Beacon for assessment and referral. If you are unsure whether a member has mild to moderate mental health issues or severe mental health issues, contact Beacon and they will screen the member to make that determination and refer them to one of their network providers. Contact Beacon by submitting a referral request using the PCP Referral Form on the Behavioral Health page of the Alliance’s provider website. Providers and members can also call Beacon at (855) 765-9700 24 hours a day, 365 days a year. Beacon providers will ask members to sign a statement...
The behavioral health services covered by the Alliance include:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition (prior authorization from the Managed Behavioral Health Organization required).
- Outpatient services for the purposes of monitoring drug therapy.
- Outpatient laboratory, drugs, supplies and supplements (excluding anti-psychotic drugs which are covered by Medi-Cal FFS).
- Psychiatric consultation.

The same mental health benefits available to Medi-Cal members are available to CCS members. Family therapy with the member present is also covered for CCS eligible members. Coverage of mental health services under the CCS benefit is available when the member is CCS eligible and the rendering provider is a CCS paneled mental health provider. Access to these benefits follows the same process as Medi-Cal. Members and PCPs may contact Beacon through their toll-free number, (855) 765-9700, 24 hours a day, 365 days a year. Beacon providers will ask members to sign a statement authorizing the clinician to share clinical status information with the member’s PCP, and for the PCP to respond with additional member status information to the extent permitted by law. Members may elect to authorize or refuse to authorize release of any information except as necessary to comply with federal, state and local laws.

Family therapy and couples counseling for relational problems is excluded from Alliance covered services. However, family therapy with the member present is covered for CCS eligible members.

Behavioral Health Treatment (BHT) for Autism Spectrum Disorder (ASD) and other developmental disorders is a covered benefit for eligible Medi-Cal members. Prior authorization from the Managed Behavioral Health Organization, Beacon Health Options, is required. BHT services include Applied Behavioral Analysis and other evidence based services aimed at shaping behavior. This particular benefit is available for members under the age of 21. The role of the PCP is important to identify and refer children who are in need of behavioral health treatment for autism or other developmental conditions, as well as to provide medical follow-up for commonly co-occurring medical disorders. Beacon administers this benefit on behalf of the Alliance, and providers can refer members to Beacon by contacting them at (855) 765-9700. Providers may also contact Beacon for assistance in determining or meeting the diagnostic criteria.

The Alliance will continue to cover outpatient laboratory, supplies, supplements, drugs (excluding anti-psychotic drugs, which are covered by Medi-Cal FFS and require a Treatment Authorization Request to be accessed by a PCP for a member) and behavioral health services provided by PCPs. Beacon offers a Decision Support service in which PCPs may contact Beacon to request a psychiatric consultation for medication management or to discuss behavioral health concerns managed by the PCP.
For more information on the Alliance Medi-Cal behavioral health benefits, see Policy 405-1305 – Behavioral Health Services and Policy 404-1313 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

**Behavioral Health Services: Alliance Care IHSS Program**

**Behavioral Health Services – Inpatient**

Behavioral health care services in a participating hospital will be provided to Alliance Care IHSS members when ordered and performed by a participating behavioral health professional. Prior authorization is required.

Behavioral health services are provided through Beacon Health Options. To access behavioral health services, the member should call Beacon Health Options at (800) 808-5796 and identify him/herself as an Alliance member. There is no copayment associated with inpatient behavioral health services.

Diagnosis and inpatient treatment of a behavioral health condition includes services for all mental conditions and for substance use disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. This includes but is not limited to the following treatment of Severe Mental Illness (SMI), and Serious Emotional Disturbance (SED) of a child:

- Schizophrenia.
- Schizoaffective disorder.
- Bipolar disorder (manic-depressive illness).
- Major depressive disorders.
- Panic disorder.
- Obsessive-compulsive disorder.
- Pervasive developmental disorder or autism.
- Anorexia nervosa.
- Bulimia nervosa.

**Behavioral Health Services – Outpatient**

Behavioral health care services will also be provided to Alliance Care IHSS members on an outpatient basis. You may refer a member or members can self-refer for outpatient services. Prior authorization is required for psychological and neuropsychological testing, but not for other behavioral health outpatient services.

Outpatient behavioral health services are provided through Beacon Health Options. To access behavioral health services, the member should call Beacon Health Options at (800) 808-5796 and identify him/herself as an Alliance member.

**Copayment**

The copayment for Alliance Care IHSS members is $10 per visit.
Services include, but are not limited to treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect; domestic violence; substance abuse in the family; divorce; and/or bereavement. Also included is the involvement of family members in the treatment process, to the extent that the provider has determined it is appropriate for the health and recovery of the Alliance member. Services are offered for all mental conditions and for substance use disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. This includes but is not limited to the following treatment of Severe Mental Illness (SMI), and Serious Emotional Disturbance (SED) of a child:

- Schizophrenia.
- Schizoaffective disorder.
- Bipolar disorder (manic-depressive illness).
- Major depressive disorders.
- Panic disorder.
- Obsessive-compulsive disorder.
- Pervasive developmental disorder or autism.
- Anorexia nervosa.
- Bulimia nervosa.

**Telehealth Services: Mental Health**

Telehealth services are available for mild to moderate mental health services for Medi-Cal and IHSS members. These services are managed through Beacon Health Options. Mental Health services offered through telehealth are specific services for members who are unable to receive outpatient psychopharmacology and/or psychotherapy treatment locally due to a lack of available resources in their geographic area. It is ideal for rural settings and other locations where professional services would not otherwise be readily available, interim coverage when a psychiatrist, psychologist and/or mental health clinician is unavailable, or other situations that would prevent or delay service delivery. The goal is to improve access to and delivery of psychopharmacology and/or psychotherapy services to ensure that all members receive the best possible care regardless of geographic location.

Telehealth services are conducted from a distant site equipped with a secure two-way, real-time interactive telecommunication system to a member in a qualifying originating site, or in a home-based setting. A mental health provider has the capacity to provide the following via a secure two-way, real-time interactive telecommunication system:

- Psychopharmacology Diagnostic Assessment
- Ongoing Psychopharmacological Services
- Psychiatric Diagnostic Evaluation
- Ongoing psychotherapy services
Vision Services: Medi-Cal

The Alliance sub-contracts with Vision Services Plan (VSP) to provide vision services to Alliance members. Members under the age of 21 or who are residing in a skilled or intermediate nursing facility are eligible for both refractive eye exams and eyeglasses. Members 21 years of age and older who are not residing in a skilled or intermediate nursing facility are eligible only for refractive eye exams. Lenses and frames are not a benefit for these members. For refraction services or eyeglasses, members must go to a VSP Medi-Cal participating provider. Participating providers can be found in the VSP Provider Directory.

For information on how to become an approved optometrist, please reference Policy 300-4160-Optometrists Reimbursement for Medical Services.

Vision Services: Alliance Care IHSS

Not a covered benefit.

Dental Services: Alliance Care IHSS

Not a covered benefit.

Child Health and Disability Prevention Program

The Child Health and Disability Prevention (CHDP) Program is a preventive program to ensure periodic health assessments and services for low-income children and youth in California. CHDP is funded by both federal and state governments to ensure the provision of a pre-specified maximum number of preventive-care visits for children under 21 years who are enrolled in Medi-Cal.

Health assessments are provided by CHDP-enrolled private physicians, local health departments, community clinics, managed care plans and some local school districts.

Some of the services covered by CHDP include, but are not limited to:

- Developmental assessment.
- Health and development history.
- Immunizations.
- Laboratory tests and procedures (including tests for serum levels of lead).
- Periodic comprehensive health examinations.
- Psychosocial screening.
- Speech screening.
- Vision screening.

Early Start Program for Developmentally Disabled Infants and Toddlers: Medi-Cal

The Early Start Program is California's response to federal legislation ensuring that early intervention and medically necessary diagnostic and therapeutic services are provided to infants and children with
developmental delays or disabilities — and that such services are provided in a coordinated, family-centered network.

Alliance members eligible for early intervention services are infants and toddlers from birth to 36 months for whom documented evaluation and assessment confirms that they meet any one of the following criteria:

- Child has a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- Child has an established risk condition(s) of known etiology, with a high probability of resulting in delayed development; or
- Child is at high risk of having a substantial developmental disability due to a combination of risk factors.

California state legislation requires that you refer children between 0-36 months to the Early Start Program for evaluation if they exhibit a significant developmental delay, have multiple risk factors, or have an established risk factor; this referral must take place within 48 hours of your assessment.

PCPs should collaborate in the development of a child’s IFSP (the Regional Center’s Individualized Family Service Plan), and monitor and coordinate all medical services with Regional Center staff, when applicable.
Section 8
Referrals and Authorizations

Referrals
Members must obtain a referral from their PCP before scheduling an appointment with any other physician, except for a specialist to specialist referral for a CCS eligible condition or for the self-referral services described below under “Self-Referral.” Authorization Requests must be submitted prior to provision of a service unless it is medically urgent or will result in an unnecessary extension of a hospital stay.

For authorization purposes, a requested service or medical equipment is approved if it is a covered benefit and is determined to be medically necessary. For more information on Medical Necessity see Policy 404-1112 - Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests.

Referral Requests for members under 21 years of age will be reviewed for potential CCS medical eligibility. For more information, please see Policy 404-1305 – Screening and Referral of Medically Eligible Children to California Children’s Services (CCS) Program.

Referral Consultation Requests
PCPs should submit a Referral Consultation Request (RCR) when referring members for specialty physical health care to a provider within the Alliance’s service area. PCPs should use an Authorized Referral form when referring members for specialty care to a provider outside of the Alliance’s service area, or when referring Medi-Cal members for specialty care related to treatment of a CCS-eligible condition.

Referrals are not required from PCPs in the following four situations:

1. Emergency care
2. Direct specialist to specialist referrals (require Authorized Referral completed by the referring specialist and submitted via fax to the Alliance)
3. Direct specialist to occupational and physical therapy referrals (require RCR from the referring specialist).

For WCM CCS-eligible members, an authorization is required for all Specialist referrals. As with Authorized Referrals, referrals are not required for administrative members. PCPs are required to maintain a referral tracking system for members sent to specialists for care, and must follow up within a reasonable time frame to ensure that the member kept the appointment and obtain the specialist's report and recommendations.

Referrals are not required for members seen in the Emergency Department (ED) to the following specialists for the referenced treatments:

1. Orthopedic surgeons: for documented or suspected fracture, sprains, and strains
Section 8. Referrals and Authorizations

2. General surgeons: For chronic cholecystitis

3. Ophthalmologists: For emergency retinal detachment; corneal abrasions; burns and retained foreign bodies; acute ocular infections; and glaucoma emergencies

4. Pain management: For acute or acute on chronic lumbar and/or cervical radiculopathy

For more information, please see Policy 404-1303 – Referral Consultation Request Process.

Referrals can be submitted online, by mail or by fax. When submitting via mail or fax, please be sure to date and sign the referral. You may submit referrals:

Online by logging into your Alliance Provider Portal account.

By fax to (831) 430-5515.

By mail to: Central California Alliance for Health
P.O. Box 660015
Scotts Valley, CA 95067-0015

View a sample of the Referral Consultation Request form, or instructions to complete the referral.

Some common examples of situations in which a referral is required include:

- Laboratory and diagnostic testing (non-routine, out-of-network).

Referral Guidelines

Specialists need the medical information on the referral to be as specific as possible. Care should be taken by the PCP in completing referrals since what is authorized will determine the scope and duration of services and claims paid for these services. You and/or other referring physicians are responsible for verifying the list of contracted providers for all referrals to ensure that the referral is being made to an appropriate Alliance network provider. CCS-eligible members must be referred to CCS-paneled specialists, when applicable.

Referrals to non-contracted and/or out-of-network providers will be authorized under compelling medical circumstances and/or when medically necessary services are not readily available within the Alliance network.

The referral specialist is responsible to inform the PCP, of the patient’s status and proposed interventions throughout the course of treatment. The PCP is responsible for maintaining the referral tracking system.

Unless otherwise specified, a standing referral will expire in 90 days; if indicated on the referral, however, the authorization may be valid for up to one year, after which a new referral is required.

All associated episodes of care for the listed items are covered with a referral override for that specialist, if the follow up care is for the original diagnosis code. For more information on the referral process, please see Policy 404-1303 - Referral Consultation Request Process.
**Serious and Complex Medical Conditions**

Providers should develop a written treatment plan for members with complex and serious medical conditions. The plan must provide for a standing referral or extended referral to a specialist, as appropriate. Regardless of the length of the standing referral, all specialist providers are required to send the PCP regular reports on the care and status of the patient.

The written treatment plan should indicate whether the patient will require:

- Continuing care from a specialist or specialty care center over a prolonged period of time.
- Standing referral visits to the specialists.
- Extended access to a specialist because of a life threatening, degenerative or disabling condition involving coordination of care by a specialty care practitioner (for extended specialty referrals, the requesting provider should indicate the specific health care services to be managed by the specialist vs. the requesting physician).

For additional information on extended referral authorization, please see Policy 404-1306 - Extended Referral Authorization.

**Standing Referrals to an HIV/AIDS Specialist: Medi-Cal**

Patients with HIV or AIDS are designated as administrative members and are deemed as having “a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative, or disabling” — thus assuring that the member has a standing referral to a specialty HIV/AIDS provider.

To qualify as an HIV/AIDS Specialist, a provider must have a valid license to practice medicine in the state of California and meet at least one of the following criteria:

- Credentialed as an HIV Specialist by the American Academy of HIV Medicine.
- Board certified, or has earned a Certificate of Forms Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties; or
- Board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties; and
- In the immediately preceding 12 months, has clinically managed medical care to a minimum of 25 patients who are infected with HIV and has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients; or
- In the immediately preceding 24 months, has clinically managed medical care to a minimum of 20 patients who are infected with HIV and has completed any one of the following:
  - In the immediately preceding 12 months, has obtained Board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties;
In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients; or

In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients, and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

If properly certified a provider has the option, to be listed in the Provider Directory as an HIV/AIDS specialist. For more information on standing referrals to HIV Specialists, please see Policy 404-1312 - Standing Referrals to HIV/AIDS Specialists.

*Audiology, Podiatry, Occupational and Speech Therapy and Incontinence Creams and Washes: Medi-Cal*

Alliance provides coverage for Audiology, Podiatry and Speech Therapy services and for Incontinence Creams and Washes.

Audiology: A referral is required from the member’s PCP.

Podiatry Services and Occupational and Speech Therapy: Alliance Medi-Cal members may have an initial visit (1 visit) with a podiatrist or speech or occupational health therapist without needing a referral from their PCP. The purpose of this visit would be to evaluate whether there is a need for treatment. Any additional visits or further treatment would require authorization from the Alliance. If the provider wishes to submit an authorization request for treatment, he/she would submit the results of the initial evaluation/consultation along with the authorization request.

Incontinence Creams and Washes: providers may continue to provide these supplies and submit claims for reimbursement following guidelines for authorization, threshold amounts and pricing.

**Assistance with Referral Consultation Requests**

View a sample of the Referral Consultation Request form, or Instructions to Complete the Referral. If you are unable to determine if a referral is required, please call our Service Authorization Coordinator at (800) 700-3874 ext.5506 (please have the CPT Procedure Code available to facilitate the research). You may also fax your completed Referral Consultation Request Form to (831) 430-5515.

**Out-of-Service-Area Referrals**

When a member needs specialty care or procedures, the member’s PCP should refer the member, the majority of the time, to a contracted provider within the Alliance’s service area.

If there is no contracted provider available within the service area, or the condition is complex, the PCP may refer the member to a non-contracted provider within the service area. The process for making these referrals is for the PCP to complete a Referral Consultation Request Form, sending one copy to the referral provider and one copy to the Alliance. The Alliance must review and approve referrals to out-of-service-area providers before the service can be provided. For in-service-area referrals, the Alliance copy is for review and
payment purposes only – the Alliance does not approve or deny in-service-area referrals. This helps to ensure that appropriate medical criteria are met and that the member is being referred to an appropriate provider. The process for these referrals is for the PCP to complete and submit an Authorization Request form to the Alliance.

Referrals to specialty care for members with a CCS-eligible condition—whether initiated by the PCP or another specialist, and whether being referred to an in-service-area or out-of-area provider—must be authorized by the Alliance. This is to ensure that CCS members are being directed to CCS paneled providers, as appropriate, when care is being provided for the CCS-eligible condition.

In general, the reasons for referring to a provider out of our service area are:

- The necessary procedure or service is not available through one of our in-service-area providers, or the condition is complex. The PCP may refer the member to a non-contracted provider within the service area by completing a Referral Consultation.
- The expertise required for consultation is beyond what is available through our in-service-area provider network.
- The member’s medical needs are sufficiently complex to require service out of the area.

In the event of an urgent/emergent medical situation outside of the Alliance service area, the facility providing the service is required to contact us within one business day to confirm eligibility and service authorization.

All services requested will be reviewed for clinical appropriateness by an Alliance nurse, with final decisions made by the Chief Medical Officer or Medical Director.

For more information on out-of-service-area referrals, please see Policy 404-1310 - Authorization Process for Referrals to Out of Service Area and Non-Contracted Specialty Providers.

**Self-Referral: No Authorization or Referral Required for Medi-Cal**

Alliance Medi-Cal members may access certain services without a referral from a PCP, as long as the provider they choose is a member of the Alliance network and is within the Alliance’s service area:

- Asthma education with an Alliance-approved asthma education provider.
- Diabetes education with an Alliance-approved prediabetes/diabetes education provider (except for CCS members, who will be directed to CCS paneled diabetes providers, as appropriate).
- Tobacco cessation support program.
- Other health education and disease management programs.
- Urgent Visit primary care services at Urgent Visit access sites.
- The limited allied health benefit allows members to self-refer for acupuncture, chiropractic, podiatry (note that some podiatric visits require authorization), speech and occupational therapy services. A maximum of two visits are allowed per month. Any additional visits or course of treatment will require an authorization with approval from the Alliance and the number of treatments allowed is based on the member’s medical condition and current Alliance and Medi-Cal guidelines and benefits. For WCM
CCS-eligible members, an authorized referral is required for initial evaluation/consultation for Podiatry, Speech, and Occupational Therapy.

- Mental health services (except for psychological testing and BHT). For WCM CCS-eligible members, an authorized referral is required to ensure that the member is referred to a CCS paneled provider.
- Alliance Medi-Cal members also may self-refer to any willing Medi-Cal provider for family planning and sensitive services. Female Alliance members may self-refer to any willing Medi-Cal OB/GYN within the Alliance’s service area for routine well woman care.
- Female Alliance Medi-Cal members may self-refer to any willing medical OB/GYN for pregnancy services, or self-refer to a qualified certified nurse practitioner or certified nurse mid-wife, including use of alternative birth center facilities.

No prior authorization is required for emergency/urgent services and emergency hospital admissions. For emergency inpatient admissions or emergency services, the hospital should contact the Alliance for verification of the member’s eligibility. All inpatient hospital stays require an authorization after admission. Authorization can be obtained by faxing a Hospital Admission Face Sheet and clinical documentation to the Utilization Management Department to (831) 430-5850. Contracting facilities are obligated to notify the Alliance within one day of admission to obtain authorizations, and confirm the length of stay and level of care needed by the patient.

Administrative members, i.e., those not linked to a PCP, may self-refer to a Medi-Cal provider within the Alliance’s service area for covered benefits. In addition, authorization from the Alliance is not required for members with other health coverage including Medicare since the Alliance is not the primary payer.

No prior authorization is required for family planning and sensitive services. Family planning services include birth control and pregnancy testing and counseling. Sensitive services include pregnancy testing and counseling, birth control, AIDS/HIV testing, sexually transmitted infection (STI) testing and treatment and termination of pregnancy. These services are listed alphabetically below:

- Abortion/termination of pregnancy (legal, unspecified, failed).
- Contraception and contraceptive management, including provision of contraceptive pills/devices/supplies and tubal ligation and vasectomy.
- Diagnosis and treatment of STIs if medically indicated.
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Health education and counseling necessary to make informed choices and understand contraceptive methods.
- High-risk sexual behavior.
- Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods.
- Limited history and physical examination.
- Observation following alleged rape or seduction.
- Phthirus pubis (pubic lice) and Pubic Scabies.
- Pregnancy exam or test, pregnancy unconfirmed.
- Rape examination.
- Screening, testing and counseling of at-risk individuals for HIV and other STIs and referral for treatment.

For more information about which services Medi-Cal members may access without a referral from a PCP, please see the following policies:

Policy 404-1309 - Member Access to Self-Referred Services
Policy 404-1702 - Provision of Family Planning Services to Members
Policy 404-1707 Acupuncture Services for Medi-Cal Members
Policy 404-1710 Pediatric Therapies for Medi-Cal Recipients
Policy 405-2110 Disease Management Programs

### Prior Authorizations

Individual Authorization Requests (ARs) are reviewed by a Prior Authorization nurse or Pharmacist according to predetermined criteria, protocols and the medical information from the physician or other provider. In some cases, the nurse may need to contact the provider directly to request additional information or one of the Alliance Medical Directors or Pharmacists may need to speak directly with the provider to discuss the request.

Authorization Requests (AR) for members under 21 years of age will be reviewed for potential CCS medical eligibility. For more information, please see Policy 404-1305 – Screening and Referral of Medically Eligible Children to California Children’s Services (CCS) Program.

Only licensed medical professionals employed by the Alliance make decisions about ARs. Only our Chief Medical Officer, Medical Directors or Pharmacists have the authority to modify or deny ARs. Authorization decisions are based upon evidence-based Alliance policies as well as nationally recognized standards including:
1. Title 22 criteria
2. Medi-Cal Medical Necessity Guidelines (when available)
3. California Children’s Services (CCS) Medical Necessity Guidelines (when available)
4. Alliance Health Services & Pharmacy Guidelines and Policies & Procedures approved by the
5. Continuous Quality Improvement Committee and the Pharmacy and Therapeutics Committee.
6. Evidence-based guidelines, such as:
   - MCG (formerly Milliman Care Guidelines)
   - Medicare (CMS) Guidelines
   - Consensus statements and nationally recognized standards of practice.
7. Guidelines developed by other health plans.
8. Expert opinion:
   a. Clinical advisors serving on Alliance Committees
   b. Outside Independent Medical Review

For more information on Medical Necessity, see Policy 404-1112 - Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests.

For more information about timely submission of ARs, please see Policy 404-1201 - Authorization Request Process.

Medical Services Requiring Prior Authorization

Common medical services or procedures that generally require prior authorization include:
   - Allergy treatment. (please see Policy 404-1734 – Immunotherapy Authorization).
   - Genetic Testing (Please see Policy 404-1715 - Genetic Testing)
   - Home Health services.
   - MRIs and unlisted CT scans.
   - Physical, occupational and speech therapy.
   - Podiatric treatment.
   - Outpatient surgery.
   - Non-emergency hospitalizations, except for an obstetrical delivery.
   - Medical supplies and Durable Medical Equipment (DME).
   - Requests for referral to an out-of-service-area provider/facility or a non-contracted provider/facility.
   - Non-Medical Transportation
   - Palliative Care Outpatient Services
   - Sleep studies (please see Policy 404-1711 – Sleep Study (Polysomnography/Sleep Disorder Testing) Authorizations)
   - Sclerotherapy procedure (please see Policy 404-1203 – Surgical Treatment of Varicose Veins)
   - Electromyography, Nerve Conduction Studies (please see Policy 404-1713 –Electromyography, Nerve Conduction Studies)
   - Drugs or treatment interventions not included in our Formulary (or if the quantity requested is more than a 90-day supply for maintenance drugs and a 30-day supply for all other agents).
   - Total Joint Replacement Surgery (Please see Policy 404-1733 – Total Joint Replacement)
Acupuncture Services – Medi-Cal

Prior authorization is required for more than two acupuncture treatments and is limited to 20 visits per authorization for treatment of pain. Note that members can self-refer for up to two visits per month. For more information, please see Policy 404-1707 Acupuncture Services for Medi-Cal Members.

Acupuncture and Chiropractic Services - IHSS

Prior authorization is required for acupuncture and chiropractic care, which are limited to 20 visits per benefit year.

Laparoscopic Cholecystectomy and Laparoscopic Cholecystectomy with Cholangiogram

Elective, emergent, or urgent laparoscopic cholecystectomy, or laparoscopic cholecystectomy with cholangiogram, do not require prior authorization. If inpatient admission is required, the admitting facility must notify the Alliance of admission within one business day. Please see Policy 404-1204 —Laparoscopy – Cholecystectomy Authorization Process for more information.

Medical Supplies and DME

For more information about requests for Medical Supplies and DME, see Policy 404-1603 - Medical Supplies Authorizations or Policy 404-1601 - Durable Medical Equipment (DME) Authorization.

Physical Therapy

Authorization requests will be considered according to the criteria and procedures described in Policy 404-1706 - Physical Therapy. For coding information see Section 10. Claims for designated codes that allow flexibility in providing a variety of physical therapy modalities without having to request adjustments to the initially submitted AR as the treatment plan changes.

Behavioral Health Services Requiring Prior Authorization

Behavioral health services that require prior authorization include:

- Psychological and neuropsychological testing.
- Behavioral Health Treatment (BHT).

To request authorization for a psychological test or BHT for an Alliance Medi-Cal member contact Beacon Health Options via their toll-free number 24 hours a day, 365 days a year at (855) 765-9700.

Submitting Authorization Requests

Prescribing physicians may request authorization by completing an Authorization Request (AR) Form and submitting it via:

- The Alliance Provider Portal.
- Fax to (831) 430-5850.
Section 8. Referrals and Authorizations

- U.S. post to: Central California Alliance for Health, P.O. Box 660015, Scotts Valley, CA 95067-0012.

For questions regarding Authorization Requests, please call (831) 430-5506.

When a member requests a specific service, treatment, or referral to a specialist, it is the PCP’s responsibility to assess the medical need before providing or referring for treatment. If the service requested is not medically indicated, discuss an alternative treatment plan with the member or his/her representative.

Adherence to the following checklist for effective submission of an Authorization Request will assure the timeliest decision:

- Please complete the form — an illegible handwritten form may be returned to the provider.
- Be sure to include your name, address and contact number — and fax number.
- Be sure to include member’s name, address, age, sex, date of birth, and identifying information such as the member’s Alliance ID Number.
- The Medi-Cal identification number must be correct. Refer to the Medi-Cal card if necessary.
- Enter into the appropriate box the description of the diagnosis and ICD-10 or CPT code with appropriate modifiers that most closely describe the member’s condition.
- Use the correct nine-digit provider identification (NPI) number. If the patient is hospitalized, the hospital provider number must be used.
- Attach documentation that supports the medical necessity of the request to the form (in addition to providing documentation required in the Medical Justification box).
- Be sure to sign and date the form (must be signed by the referring provider).
- Submit a separate AR for each service request per member; the AR will be given a unique number that is used to facilitate reimbursement.

Routine Pre-Service Requests

The prescribing provider must complete an Authorization Request before the service is performed. For routine pre-service requests for procedures/services that can be pre-scheduled without danger of adverse outcome to the member, the Alliance will usually make a determination within 5 business days, but no longer than 14 days from receipt of the request and appropriate documentation of medical necessity.

In certain circumstances, a decision may be deferred for an additional 14 days when the member or provider requests an extension, or if the original AR did not contain sufficient information.

All decisions for Authorization Requests are communicated to the provider by fax within one business day of the decision; providers inform the member about the decision. Decisions to modify or deny Authorization Requests are communicated to the member in writing within two business days of the decision; a copy will be sent to the provider then an Authorization Request is concurrent with services being provided, the Alliance will ensure that medically necessary care is not interrupted or discontinued until the members treating physician has been notified of the decision and a care plan has been agreed upon by the treating provider/PCP that is appropriate for the medical needs of the patient.
Expedited/Urgent Requests

In medically urgent situations, you may request an expedited Authorization Request review by calling our Health Services Department at (800) 700-3874 ext. 5506 or faxing it to (831) 430-5850. Expedited Authorization Requests will be reviewed within three business days or as soon as possible after receipt of the request when the provider indicates that following a standard timeframe could seriously jeopardize the member’s life or health, or ability to attain, maintain or regain maximum function.

Post-Service Authorization Requests

If it was not possible for the provider to obtain authorization before providing a medically necessary service, we will respond to a post-service Authorization Request if it is received within 30 calendar days of initiation of the service; if received later, the retrospective Authorization Request may be denied for non-timely submission. Please note that a post-service AR must be accompanied by documentation explaining why the authorization was not requested earlier. Our response will inform the provider of the decision to approve, modify or deny the Authorization Request.

While elective surgery requires prior authorization, under exceptional medical circumstances we may provide authorization after the fact.

If an Authorization Request is submitted for a member who has obtained retroactive eligibility, it must be received by the Alliance within 60 calendar days of the date on which the member obtained eligibility or it will be denied for non-timely submission.

Following are conditions whereby an Authorization Request may be submitted for post-service consideration:

- Member’s eligibility was delayed.
- When “other coverage” will not pay the claim.
- Wheelchair repairs exceeding $500.
- When the patient hides Medi-Cal eligibility.

For more information about the authorization review process, please see Policy 404-1201 - Authorization Request Process.

Authorization Requests for Ancillary Services

Prior authorization is required for ancillary services such as home health care, medical supplies, rehabilitation services and DME. Ancillary services requiring prior authorization include, but are not limited to, the following:

- Durable Medical Equipment (purchase or rental).
- Hearing devices.
- Physical/occupational therapy.
- Speech pathology and audiologic services.
- Home Health Agency services.
Medical supplies.
Non-emergency medical transportation services.

**Hospital Inpatient Services**
Admissions to an acute-care facility or Ambulatory Surgery Center for scheduled surgery require prior authorization. All requests must be accompanied by the appropriate medical documentation including, but not limited to:

- Laboratory test results.
- X-rays.
- Medical records.
- Other reports that have relevance to the planned admission (e.g., pre-operative history and physical).

*Emergency and urgent admissions do not require prior authorization.* However, the Alliance must be notified by the facility of emergency admissions within one business day.

Discharge planning is initiated upon admission to facilitate the transition of beneficiaries to the next phase of care. The discharge planning team is multi-disciplinary and consists of the treating physician and hospital discharge planners. Physician responsibility includes participation in coordinating member discharge planning and referrals to appropriate post-discharge settings. Alliance staff will work with the hospital’s discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

For more information about hospital services please see Section 6. Alliance Covered Benefits and Services.

**Obtaining a Second Opinion**
Members, members’ parents, members’ custodial parents, members’ legal guardians, and other authorized representatives for the member may request a second opinion about a recommended procedure or service. The Alliance honors all requests for second opinions without the need for a prior authorization as long as the second provider is contracted with the Alliance and within the Alliance’s service area.

All referrals for CCS-eligible members require a prior authorization, including referrals for second opinions.

Second opinions may be rendered only by an appropriately qualified health care professional to review and treat the medical condition in question. Referrals to non-contracting medical providers or facilities may be approved only when the requested services are not available within the Alliance network.

If the provider giving the second opinion recommends a treatment, diagnostic test, or service that is medically necessary and covered by the Alliance, the PCP must provide or arrange for the service.

For more information on obtaining a second opinion, please see Policy 404-1307 - Medical Second Opinions.
Status of Authorization Requests

Our Health Services Authorization Coordinators will review AR forms for completeness and will help you with any aspect of the process, including answering questions regarding the status of ARs (800) 700-3874 ext.5511.

Deferrals and Denials

As discussed earlier in this section, decisions about requests for authorization may be deferred or denied. The most common reasons for such decisions are outlined in the chart below.

When a request is denied, a Notice of Action letter will be mailed to the member no later than the second business day after the decision, with a copy sent to the provider. If the denial is a result of insufficient information from the provider, we will inform the member that the case will be reopened when complete information is received. The denial letter will explain the reason for denial of the request and will provide information about the member’s right to appeal the decision.

If you need clarification of the reason your AR was denied, please call the Alliance’s Authorization Coordinator at (800) 700-3874 ext.5506.

Notes on the Status of Authorization Requests

<table>
<thead>
<tr>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved as Requested</td>
<td>You may provide service as requested. Please remember to include the AR# on your claim.</td>
</tr>
<tr>
<td>Approved as Modified</td>
<td>Most Common Reasons for Approved as Modified:</td>
</tr>
<tr>
<td></td>
<td>• Fewer visits are authorized than were requested on the AR.</td>
</tr>
<tr>
<td></td>
<td>• Number of inpatient days requested on the AR is not within the guidelines on length of stay for the requested procedure.</td>
</tr>
<tr>
<td></td>
<td>• Dates of service requested on the AR do not match the dates that the member is Alliance eligible.</td>
</tr>
<tr>
<td>Extended / Deferred</td>
<td>Most Common Reasons for Extended / Deferred AR:</td>
</tr>
<tr>
<td></td>
<td>• AR form incompletely filled out; often lacks Procedure (CPT) and/or diagnosis codes (ICD-10), and/or narrative information on the procedure and/or codes that are being requested.</td>
</tr>
<tr>
<td></td>
<td>• Insufficient medical information supplied on or with the AR form to enable appropriate medical decision.</td>
</tr>
<tr>
<td></td>
<td>• Necessary equipment pricing catalog pages not submitted.</td>
</tr>
</tbody>
</table>
## Section 8. Referrals and Authorizations

<table>
<thead>
<tr>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
</table>
| **Denied** | **Common Reasons for a Denial:**  
  - Request is for dental care services, which are Medi-Cal services authorized and reimbursed by an agency *other than the Alliance*.  
  - Request is for specialty mental health services, which are services, authorized and reimbursed by county Mental Health Plans.  
  - Documentation insufficient to support the medical necessity for the requested procedure/equipment.  
  - Request was not submitted in a timely fashion.  
The Alliance will send a denial letter to the member, giving an explanation for the denial and information about rights to appeal the decision.  
If you need clarification of the reason your AR was denied, please call the Alliance’s Authorization Coordinator at (800) 700-3874 ext.5504. |

For more details, see Policy [404-1109 - Disclosure of Utilization Management Process to Providers, Members and the Public](http://www.ccah-alliance.org).

### Self-Referrals (No Authorization or Referral Required): Alliance Care IHSS

Alliance Care IHSS members may access certain basic services without a referral from a PCP, as long as the provider they choose is a member of the Alliance network and is within the Alliance’s service area:

- Asthma education.  
- Diabetes education.  
- Other health education programs.  
- Alliance Care IHSS members may self-refer to any contracted provider within the Alliance’s service area for family planning services, annual well woman services and pregnancy services.

For more information about self-referral, please see the following policies:

Policy [404-1309 - Member Access to Self-Referred Services](http://www.ccah-alliance.org).

Policy [404-1702 - Provision of Family Planning Services to Members](http://www.ccah-alliance.org)

Newborn examinations and nursery care are covered while the mother is hospitalized; newborns may also be eligible for care during the first 30 days if they do not qualify for Medi-Cal.

**No prior authorization is required for emergency/urgent services and emergency hospital admissions.** For emergency inpatient admissions or emergency services, the hospital should contact the Alliance for verification of the member’s eligibility. All inpatient hospital stays require an authorization after admission. Authorization can be obtained by sending a Hospital Admission Face Sheet and clinical documentation to the UM Department. Contracting facilities are obligated to notify the Alliance within one day of admission to obtain authorizations and to confirm the length of stay and level of care needed by the patient.

For more information on hospital services, please see Section 6. Alliance Covered Benefits and Services.
The Alliance will provide an external, independent review process to examine decisions regarding (a) denial, delay or modification of service based upon medical necessity and (b) experimental or investigational therapies. For additional information about external independent medical reviews, see Policy 404-1113 - External Independent Medical Review. For more details refer to Policy 404-1109 - Disclosure of Utilization Management Process to Providers, Members and the Public.

### Summary of Referral and Authorization Requirements for Medi-Cal

<table>
<thead>
<tr>
<th>Service</th>
<th>Linked members who are assigned to a Primary Care Physician.</th>
<th>Un-linked or administrative members who do not have a PCP assignment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral / specialty consultation (non - CCS)</td>
<td>Prior Approval and authorization are not required. PCP completes “Referral / Consultation” form and submits to the Alliance.</td>
<td>Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.</td>
</tr>
<tr>
<td>Referral / specialty consultation (CCS)</td>
<td>Prior authorization approval is required. PCP or specialist complete “Authorization Request” form and submit to Alliance for review.</td>
<td>PCP or specialist complete “Authorization Request” form and submit to Alliance for review.</td>
</tr>
<tr>
<td>Referral / specialty consultation – out-of-area</td>
<td>Prior authorization approval is required. PCP or specialist complete “Authorization Request” form and submits to Alliance for review.</td>
<td>Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.</td>
</tr>
<tr>
<td>Allergy Treatment</td>
<td>PCP completes the Referral Consultation form for an initial evaluation and submits the form to the Alliance. Additional treatment requires a prior authorization request with approval from the Alliance.</td>
<td>Member may self-refer for an initial evaluation. Provider must accept Medi-Cal and bill the Alliance. Additional treatment requires an authorization.</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>The initial Physical Therapy evaluation and treatment requires a Referral Consultation Request form from a member’s linked PCP, or treating physician, for claims payment. The Referral Consultation Request includes evaluation and treatment of up to 12 PT encounters. Additional treatment requires a prior authorization request with approval from the Alliance.</td>
<td>For those members who are Administrative Members, or non-PCP linked, a provider prescription is required for an initial evaluation and treatment.</td>
</tr>
<tr>
<td>Podiatry, Speech, Occupational Therapy</td>
<td>Members may self-refer for an initial evaluation. Treatment requires a prior authorization request with approval from the Alliance. The number of treatments is based upon current Alliance and Medi-Cal guidelines and benefits.</td>
<td></td>
</tr>
</tbody>
</table>
# Section 8. Referrals and Authorizations

## Referral Guidelines

<table>
<thead>
<tr>
<th>Service</th>
<th>Linked members who are assigned to a Primary Care Physician.</th>
<th>Un-linked or administrative members who do not have a PCP assignment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic</td>
<td>Members can self-refer up to a maximum of 2 treatments per month combined with limited allied health services. Additional treatments require a prior authorization request with approval from the Alliance.</td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Members can self-refer up to a maximum of 2 treatments per month combined with limited allied health services. Additional treatments require a prior authorization request with approval from the Alliance.</td>
<td></td>
</tr>
<tr>
<td>Family planning and sensitive services</td>
<td>Member can self-refer to any provider that is a Medi-Cal provider.</td>
<td></td>
</tr>
<tr>
<td>OB care</td>
<td>Member can self-refer to any in-area Medi-Cal obstetrical provider.</td>
<td></td>
</tr>
</tbody>
</table>

### Authorization required for:

- **DME, medical supplies, prosthetics and orthotics**
  - Purchase: individual item over $250.00
  - Repair or Maintenance: over $500
  - Incontinence supplies: over $165

- **Hospital care**
  - Any elective admission including surgical procedures
  - All transplants

- **Imaging procedures**
  - MRI
  - PET scans
  - Unlisted ultrasound, nuclear medicine and CT

- **Diagnostic procedure**
  - Cardiac catheterizations
  - BRCA and oncotype testing
  - Small bowel video endoscopy
  - PCTA

- **Surgical or therapeutic procedures**
  - Outpatient procedures done in a free standing surgery center or outpatient hospital
  - Implants surgically placed in an Outpatient/Ambulatory Surgical Center which exceed in aggregate $2500.00
  - Office based procedures that could be cosmetic in nature
  - Nutritional supplements and TPN
  - Immune globulin greater than one injection
  - Auditory therapy

- **Home Health**
  - Requires authorization. The Alliance will guarantee payment for the initial home health evaluation for members discharged from the hospital
### Referral Guidelines

<table>
<thead>
<tr>
<th>Service</th>
<th>Linked members who are assigned to a Primary Care Physician.</th>
<th>Un-linked or administrative members who do not have a PCP assignment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Hearing aids</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-emergency medical transportation – any medical transportation request requires prior authorization</td>
<td></td>
</tr>
</tbody>
</table>
Section 9
Coordination of Benefits

General Rules to Follow

Some Alliance members have Other Health Coverage (OHC) in addition to their Alliance coverage. Specific rules govern how benefits must be coordinated in these cases. The Alliance is not liable for the cost of services for members with OHC who do not obtain the services in accordance with the rules of their primary insurance. If a member elects to seek services outside of the framework of his or her primary insurance, the member is responsible for the cost.

Other health coverage entities include but are not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champ VA.
- Medicare, including Medicare Part D plans, Medicare supplemental plans and Medicare Advantage (Preferred Provider Organization [PPO] HMO, and fee-for-service) plans.

Other health insurance information should be verified on the Alliance Provider Portal prior to submission of claims. To coordinate benefits for a member who has active OHC coverage, providers must bill the primary insurance first. If there is any balance remaining after payment is received from the primary insurer, you should submit a claim to the Alliance along with an EOB from the primary payer. Claims for members with one or more than one policy will deny without the EOB from the primary carrier or proof that the member does not have OHC. For more information on coordination of benefits, see Policy 702-1750 - Coordination of Benefit Guidelines for Providers.

Medi-Cal

Federal and state laws require that all available health coverage be exhausted before billing Medi-Cal. Thus, when a Medi-Cal member has other health coverage, the Alliance becomes the secondary payer, with Medi-Cal always as the payer of last resort.

It is the responsibility of the provider to verify their patient’s eligibility; this can be done on the Alliance provider website through the Provider Portal. If the member shows OHC or Medicare eligibility, the services rendered must be billed to the primary insurance first within the rules of the primary insurance. The claim is then sent to the Alliance with the primary insurer’s explanation of benefits.
Section 9. Coordination of Benefits

When an Alliance member’s primary insurance has copayments and/or deductibles, the member cannot be asked to pay, as long as he/she is obtaining benefits within the rules of the primary insurance. The exception to this is the copayments a dual eligible member would have for his/her Medicare Part D drug plan. If the primary insurance covers the service, procedures that normally require prior authorization will not require it (with the exception of pharmacy services).

The Alliance bases billing limitations on the Medicare Explanation of Member Benefits (EOMB) or OHC Explanation of Benefits (EOB) date rather than the received date. Exceptions to the billing limit can be made if it is one of the reasons allowed by Medi-Cal for late billing. Please refer to the Delay Reason Code section of the Medi-Cal Provider Manuals for the exceptions to the billing limits allowed by Medi-Cal.

Medicare has the ability to reduce claims payment, often times in the form of a penalty. For Medicare/Medi-Cal crossover claims, the Alliance may coordinate payment based upon the amount the provider is eligible to receive from Medicare after these reductions are imposed, as is further discussed in Policy 600-1041 - Medicare and Coordination of Benefits Reimbursement.

Billing for Medi-Cal Members with Other Health Coverage

Claims that involve potential payment from another health insurance carrier are processed using a coordination of benefits methodology. Providers may bill Medi-Cal for the balance, including coinsurance and deductibles. California law limits Medi-Cal’s reimbursement to an amount that, when combined with the primary’s payment, should not exceed Medi-Cal’s maximum allowed for similar services.

Hardcopy Crossover Claim Submission

To send a copy or an original claim, please confirm that your National Provider Identifier (NPI) number is on the claim. You may bill us in the same manner as you billed the primary insurer, using the same procedure codes and modifiers. It is essential that a code be given to indicate the place of service. Attach a full-page copy of the Explanation of Benefits (EOB) or Explanation of Medical Benefits (EOMB), not a partial page, with the primary insurer’s reason code descriptions to each page of the claim. Please draw a line through all other patient names and identifying numbers on all pages.

Electronic Medicare Crossover Claims

The Alliance receives Medicare/Medi-Cal automatic crossover claims electronically for professional services only at this time. If you believe that your secondary claim was processed incorrectly, please contact our Claims Department at (800) 700-3874 ext.5503. Please do not submit hard copy Medicare claims if your Medicare claims have been submitted electronically to the Alliance, as it may prolong the processing time.

Coordination of Benefits for Medicare Non-Eligible Recipients

Medicare eligibility is received from the California Department of Health Care Services and cannot be changed by The Alliance. If providers receive an Identification of Overpayment notice stating their patient has Medicare, but the provider shows ‘Member Not Eligible’, the claim should still be billed to Medicare. The Alliance will only process claims as the primary payer with the EOMB showing Medicare Non-Eligible. Copies of Medicare cards or Common Working File (CWF) printouts are not acceptable documentation.
Medicare Retro Entitlement

The Alliance routinely conducts audits to identify patients with retroactive eligibility with Medicare or OHC. If the Alliance has paid as primary in error, the provider may receive an Identification of Overpayment notification. This letter will indicate the patient information as well as the primary payer name, if applicable. Claims paid as primary in error is an overpayment and should be returned to the Alliance. Providers should follow standard coordination of benefits guidelines and resubmit their claims as crossovers for processing.

If the Alliance finds a member has Retroactive Medicare Entitlement, providers should submit their claims to Medicare/CMS retro unit along with the following documents:

- A copy of the Remittance Advice or Identification of Overpayment notification from the Alliance indicating the date overpayment was requested or recouped;
- Documentation verifying that the beneficiary was retroactively entitled to Medicare before the date of the furnished service (i.e., the official letter to the beneficiary); and,

Additional information regarding Retroactive Medicare Entitlement can be found in the CMS Manual, Sections: 70.7.2 and 70.7.3.

Coordination of Benefits Examples

A claim is filed for $60.00. The Medi-Cal allowable amount is $32.00. Medicare paid $53.90. The Medi-Cal payment on this claim would be $0.00, not the difference of $6.10.

<table>
<thead>
<tr>
<th>Provider’s Charge</th>
<th>$250.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Allows</td>
<td>$200.00</td>
</tr>
<tr>
<td>Medicare Pays</td>
<td>$160.00</td>
</tr>
<tr>
<td>(80% of Medicare allowed amount of $200.00)</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Allowable</td>
<td>$180.00</td>
</tr>
<tr>
<td>Difference</td>
<td>$20.00</td>
</tr>
<tr>
<td>Share of Cost Collected</td>
<td>$25.00</td>
</tr>
<tr>
<td>Medi-Cal would pay</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Patients with a SOC are not eligible for Medi-Cal coverage until they meet their SOC for the month of service. The provider should ask for or accept obligation from the patient for their Medi-Cal share of cost. Remember that when Medi-Cal pays for any portion of the service, the total reimbursement received for the service may not exceed the Medi-Cal allowable amount.
Example B

Provider’s Charge $250.00
Medicare Allows 200.00
Medicare Pays 160.00
(80% of Medicare allowed amount of $200.00)
Medi-Cal Allowable 190.00
Difference 30.00
Share of Cost Collected 25.00
Medi-Cal would pay $ 5.00

Alliance Care IHSS

In most cases, when an Alliance Care IHSS member has other OHC the Alliance is the primary payer — the exception would be if the member is the primary subscriber and the policy was in effect before he/she became covered through the Alliance.

OHC includes but is not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champ VA.
- Medicare, including Medicare supplemental plans and Medicare Advantage (PPO, HMO and fee-for-service) plans (Medicare would be primary only if the member has end-stage renal disease).

When an Alliance Care IHSS member also has OHC that is primary, s/he must treat the other insurance plan as the primary insurance company and access services under that company’s rules of coverage.

Dual Coverage

Some of our Alliance Care IHSS members have dual coverage. They may have an employer or individual plan, Medicare or Medi-Cal. Alliance Care IHSS is a commercial health plan, so it is always primary over Medi-Cal and Medicare. In order for an Alliance Care IHSS member’s OHC to be primary, the member would have to be the primary subscriber on the plan (rather than being a dependent) and must have been enrolled in the plan prior to the member becoming enrolled in Alliance Care IHSS.

For additional information on submitting claims for members with dual coverage, please see Section 10. Claims.
Alliance Members with Veterans Benefits

If the Alliance member is a Veteran and is eligible for Veterans Affairs (VA) health care benefits, he/she may choose to use VA services (hospitals, outpatient and other government clinics). A description of these services can be found at the VA website.

There are outpatient facilities in Capitola, Monterey, Atwater, Tulare and San Jose. There is a bus service through the VA for transportation to the Monterey, San Jose and Palo Alto facilities; the bus schedule can be found on the VA website. For inpatient facilities, contact VA Hospital in Palo Alto, which has an affiliation with Stanford or the VA Hospital in Fresno.

Members with VA benefits may use their own discretion in choosing whether to receive their care through the VA system or the Alliance — we cannot require or request that they do so but, if the member wishes, we will facilitate and coordinate their care.

Emergency Services for Veterans

Payment or reimbursement for emergency services for non-service-connected conditions in a facility other than a VA facility may be authorized under the “Millennium Bill Act.” To be eligible for this authority, the veteran must satisfy all of the following conditions:

The emergency services must have been provided in a hospital emergency department or a similar facility that is known to provide emergency care to the public.

The claim for payment or reimbursement for the initial evaluation and treatment must be for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health.

This standard would be met in the presence of an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would seriously jeopardize the health of the individual, would result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

If we receive a claim for emergency services for a member who is known to have VA benefits, the claim will be held until the facility has received payment (or formal denial) for qualified services, as described above. Once the VA has made determination, we will make a determination based on ongoing medical necessity, but will accept responsibility for coverage even when the member could have been transferred.

VA System Referrals

In certain circumstances, the VA contracts services in non-VA facilities. If we become aware of such a service resulting from a VA referral, we will determine whether the VA has accepted financial responsibility and, if so, issue a denial.

For more information on coordination of VA benefits, please see Policy 404-1703 - Alliance Members with Veteran’s Benefits.
Section 10
Claims

The Alliance follows the billing, authorization, utilization management and claims payment guidelines laid out by the Medi-Cal Provider Manual or the Explanation of Coverage (EOC) and related regulations for the other lines of business, as appropriate to the patient. However, there are a number of instances in which the Alliance has decided to differ from these standard procedures and practices. Please see below for areas where the Alliance’s policies and procedures differ from those of the state Medi-Cal program or to clarify how a provider is to operate pursuant to a policy and procedure for all lines of business.

Billing Guidelines

Medi-Cal
Since the Alliance serves Medi-Cal beneficiaries under a contract with the state to operate a County Organized Health System (COHS) the Alliance uses state policies and procedures as a point of departure. Unless there is an Alliance-specific policy, we rely on state Medi-Cal policies for the Medi-Cal program. Providers have access to all of the policies and procedures, as well as updates to the Medi-Cal Provider Manuals on the Alliance provider website.

Alliance Care IHSS
Please apply your commercial insurance office policies, including procedure codes and UB 04 and CMS form completion.

Clean Claim
A clean claim is defined as a claim which, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability, and make timely payment. Total charges on a clean claim match all services billed on that page/form.

Where to Send Claims
Paper claims should be mailed to the Alliance using the following addresses to facilitate timely processing and payment.

Medi-Cal (including Medi-Cal members with CCS eligibility)
ATTN: CLAIMS
Central California Alliance for Health
PO Box 660015
Scotts Valley, CA 95067-0015
Section 10. Claims

Alliance Care IHSS
ATTN: CLAIMS
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Claims inquiries that require documentation may be faxed to the Claims Department at (831) 430-5868.

Claim Questions

Alliance providers are encouraged to use their Provider Portal for claims inquiries. If there are any additional questions, call the Claims Department at (831) 430-5503 or (800) 700-3874 ext. 5503, Monday – Friday, 9:00 AM – 4:00 PM.

Office hours for the Claims Department phones are Monday – Friday, 9:00 AM – 4:00 PM, with a 24-hour voicemail available for messages. Any provider calling from outside of the local calling area may use the Alliance’s toll-free number. The Alliance toll-free number may be dialed from anywhere in the United States (all 50 states) as well as Canada.

Alliance phone numbers are:

Main office: (831) 430-5500
Toll-free number: (800) 700-3874
TTY Line: (877) 548-0857
Claims Department Phone Staff: (831) 430-5503
Fax number: (831) 430-5868
Provider Relations: (800) 700-3874 x5504

When calling about questions on a claim, please have the following information available:

- The Alliance Claims Control Number (CCN) and/or the Member’s Alliance ID number (if the inquiry is regarding a newborn claim billed under the mother’s ID number, please indicate this at the beginning of the call).
- Date of service.
- Dollar amount billed.
- Date claim was sent to Alliance.

Billing for State Medi-Cal Program

Effective 10/01/2019 DXC Technology serves as the Medi-Cal Fiscal Intermediary for the state Medi-Cal program. If you treat a member who is not an Alliance Medi-Cal member, you must bill DXC or the member’s Medi-Cal plan for those services. This rule applies to members whose eligibility is through another county or who have an aid-code not covered by the Alliance.

For questions and inquiries, please contact DXC directly at (800) 541-5555.
Electronic Claims Processing

The Alliance accepts and encourages claims submitted electronically. Electronic claims processing or Electronic Data Interchange (EDI) refers to the structured transmission of data between organizations by electronic means. Please see the “Information about Electronic Transactions” content later in this section for a detailed description of the EDI submission process.

Turnaround Time for Claim Reimbursement

If you believe that the Alliance has not processed your file within 30 days of our expected received date, please contact the Alliance Claims Department at (800) 700-3874 ext.5503. If you have received an RA where the claims were processed electronically and you have questions regarding the payment / denial outcome, please contact the Alliance Claims department at (800) 700-3874 ext.5503.

Claim Forms by Provider Type

The following table is a list of the types of paper claim forms used by different types of providers (e.g., PCPs, referral specialists, pharmacists, laboratories, hospitals, skilled nursing facilities and allied health practitioners).
## Claim Forms Used by Different Types of Providers

<table>
<thead>
<tr>
<th>Applies to</th>
<th>Type of Claim Form</th>
<th>Type of Provider</th>
<th>Service(s) Billed on This Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal, Alliance Care IHSS</td>
<td>CMS</td>
<td>PCPs</td>
<td>All professional services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialists Clinics Pharmacies Laboratories Allied health practitioners</td>
<td>Electronic Medicare/Medi-Cal crossover professional claims effective on April 9, 2018. Pharmacies may also use this form for DME, medical supplies, incontinence supplies, orthotics and prosthetics.</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>PM-160</td>
<td>PCPs</td>
<td>Child Health &amp; Disability Program (CHDP) services for dates of service before 12/31/17 only — and only used for Medi-Cal members. For dates of service on or after 1/1/18, these services must be billed on a standard CMS or UB claim form.</td>
</tr>
<tr>
<td>Medi-Cal, Alliance Care IHSS</td>
<td>UB-04</td>
<td>Hospitals/Clinics Laboratories</td>
<td>All professional or facility services. SNF levels of care services when billed by approved facilities for Medi-Cal members.</td>
</tr>
<tr>
<td>Medi-Cal, Alliance Care IHSS</td>
<td>25-1C</td>
<td>LTC</td>
<td>All LTC services billed with accommodation codes.</td>
</tr>
<tr>
<td>Medi-Cal, Alliance Care IHSS</td>
<td>30-1</td>
<td>Pharmacies</td>
<td>Non-compound drug prescriptions.</td>
</tr>
<tr>
<td>Medi-Cal, Alliance Care IHSS</td>
<td>30-4</td>
<td>Pharmacies</td>
<td>Compound drug prescriptions.</td>
</tr>
</tbody>
</table>

Adherence to the following checklist for effective submission of claims will assure timely payment:
Print/type clearly on Claim Forms: All claims submitted must be legible and dark enough for scanning, which will prevent your claims from being returned.

Bill on 8-1/2 x 11 paper (including attachments).

Be sure to include the patient’s full name, without abbreviating.

Always include the member’s Alliance ID Number: (Box #1a on the CMS, Box #60 on the UB):
Please bill all claims using the Alliance Member 9-digit ID number (the “-01” at the end of the Alliance ID number is not required). Please do not use the 14-digit Medi-Cal identification number.

Include Authorization Numbers (Box #63 on the UB or Box 23 on the CMS): Type all AR and referral numbers on the claim.

When services were provided in the ER, indicate this by marking box 24C on the CMS if you are not billing with a place of service in an ER setting.

Note that a quantity for each service rendered is required: please enter quantities as a single digit (e.g., “1” not “01,” “001” or “010”).

For newborn services using mom’s ID see the following claim form completion instructions in the Medi-Cal Provider Manuals:

- CMS Completion (cms comp)
- UB-04 Completion: Outpatient Services (ub comp op)

For newborn services, if the infant is using the mother’s eligibility (within the infant’s month of birth and the month following birth), enter NEWBORN INFANT USING MOTHER’S ID or NEWBORN INFANT USING MOTHER’S ID (TWIN A) or (TWIN B) in the Reserved for Local Use field (box 19) on the CMS. On the UB-04 claim form, enter the infant’s name in the Patient’s Name field (Box 8B). Enter the infant’s date of birth and sex in boxes 10 and 11. Enter the mother’s name in the Insured’s Name field (Box 58) and enter “03” (CHILD) in the Patient’s Relationship to Insured filed (Box 59).

Please do not staple attachments, as scanning equipment requires that all staples must be removed; thus, if we must perform this task, your claim may be delayed.

Please do not fold claims, as this may delay processing. Claims control staff guarantees that all claims and attachments will be kept together exactly in the order you put them in the envelope.

Billing and Coding Information
The Alliance follows the billing, authorization, utilization management, and claims payment guidelines laid out by the Medi-Cal Provider Manual or the EOCs and related regulations for the other lines of business, as appropriate to the patient. However, there are a number of instances in which the Alliance has decided to differ from these standard procedures and practices. Please see below for areas where the Alliance’s policies and procedures differ from those of the state Medi-Cal program or to clarify how a provider is to operate pursuant to a policy and procedure for all lines of business.

For information on specific procedures pursuant to a policy for all lines of business, please see below for Alliance billing guidelines:
Who bills Medi-Cal for the services of rendering providers and locum tenens physicians?

Rendering providers cannot bill directly; the group entity bills Medi-Cal for services rendered by the providers enrolled in their group. In reimbursement for locum tenens/reciprocal billing, the recipient’s regular physician may submit the claim and receive payment for covered Medi-Cal services (including emergency visits and related services) provided by a locum tenens physician who is not an employee of the regular physician. Providers should bill with modifier Q6.

Allergen Immunotherapy, 95115

To enable contracted Ear Nose and Throat and allergist providers to accurately report and be reimbursed for services provided to all Alliance members, the Alliance will reimburse professional services for allergen immunotherapy (excluding provision of single allergenic extracts) billed with code 95115 when billed in conjunction with E&M codes 99201-99215 or 99241-99245.

No authorization or referral is required.

Ambulatory Surgery Billing and Authorizations

Surgical Implants: Prior authorization is required for surgical implants. The provider must submit an Authorization Request requesting Plan approval, and must attach supporting documentation regarding the implants to be used, their cost and the procedure in which they are to be used. If the implant is to be used in a procedure which itself requires prior authorization, a single Authorization Request should be used both requesting authorization for the procedure and for the implants. If the procedure itself would not otherwise require prior authorization, an Authorization Request for the implants only should be submitted.

Billing for Outpatient Surgical Facility Services: Unless otherwise specifically identified in this guide, covered outpatient surgical facility services and supplies which are not on a surgical tray, or a post-operative pain block, or a surgical implant should be billed using the appropriate Medi-Cal specific or CPT billing codes. As noted above, providers must follow any applicable prior authorization requirements applicable to the procedure being performed.

a. Surgical Tray: the Alliance pays a case rate for surgical supplies provided on the surgical tray. Providers must bill with the appropriate CPT-4 codes (range 10000-64399 & 64531-69999) and must include either a UA or UB modifier on the claim form.

b. Post-Operative Nerve Pain Blocks: the Alliance pays a flat rate for the provision of post-operative nerve pain blocks. Providers may bill for the provision of post-operative pain blocks administered to patients where the post-operative pain block was provided on the same date of service as the surgical procedure. Providers must bill using CPT-4 codes (range 64400-64530) and should use appropriate modifiers.

Surgical Implants: Providers billing for surgical implants must include a copy of the invoice for the item and the authorization number with the claim. See Policy 600-1011 - Surgical Implantable Devices.
Biophysical and Modified Biophysical Profile

The Alliance will reimburse contracted providers for biophysical and modified biophysical profiles without referral or authorization.

CPT 76818 – fetal biophysical profile (BPP), a test to measure fetal well-being.

CPT 76819 – modified biophysical profile, combines a non-stress test and measurements of amniotic fluid (amniotic fluid index).

Services are reimbursed when providers use the appropriate billing codes for the following scenarios:

For same date of service (DOS) and same provider, replace billing code (59025 + 76805) with 76818 only.

For different DOS and any provider, with service billed within 7 days, replace (59025 + 76805) with (59025 + 76819).

For same DOS and any provider, replace (59025 + 76805) with (59025 + 76819).

There is a diagnosis restriction for high-risk pregnancy. The Alliance will reimburse contracted providers for biophysical and modified biophysical profiles without referral or authorization for high-risk pregnancy.

Members with CCS Eligibility

The CCS diagnosis code should only be added to claims in which the CCS condition is being treated.

Cardiac and Pulmonary Rehabilitation Services

The Alliance provides coverage of cardiac and pulmonary rehabilitation services for all Alliance members with prior authorization. When billing for these services, please use the following codes:

Cardiac Rehabilitation: 93798, 93797, G0422, G0423

Pulmonary Rehabilitation: G0424

For additional information please see Policies 404-1720_Private_Duty_Nursing_EPSDT_Benefit and 404-1729 - Pulmonary Rehabilitation Services.

Chiropractic X-Ray Services

The Alliance will reimburse the following amounts for contracted chiropractors when providing specific X-ray services to all Alliance members. When billing for these services, chiropractors should use only the codes shown below with an appropriate modifier: See Policy 600-1036 - Modifier Reference Grid for assistance.

Billing code: 72040 - Radiologic examination of spine (including cervical spine). No modifier (both professional and technical component), or Modifier 26 (just professional component).

Billing code: 72052 - Complete X-ray, including oblique and flexion and/or extension studies. No modifier (both professional and technical component), or Modifier 26 (just professional component).

Billing code: 72070 - Radiologic examination, spine, thoracic. No modifier (both professional and technical component), or Modifier 26 (just professional component).

Billing code: 72100 - Radiologic examination, spine, lumbosacral. No modifier (both professional and technical component), or Modifier 26 (just professional component).
Billing code: 72114 - Complete, including bending views. No modifier (both professional and technical component), or Modifier 26 (just professional component).

A referral or an Authorization Request is not required.

**DME Policies and Instruction**

- 600-1006 - Breast Pumps and Coordination of Benefits
- 600-1007 - DME Rent to Purchase Pricing
- 600-1022 - Charpentier Billing Procedure
- 600-1024 - DME Pricing
- 600-1026 - Incontinence and Medical Supply Pricing
- 600-1029 - Orthotics and Prosthetics Pricing
- 600-1032 - Wheelchair and Scooter Repair Mileage and Medicare Denials
- 600-1033 - Wheelchair, Wheelchair Accessories and or Replacement Parts for Patient Owned Equipment Pricing
- 600-1034 - Slings (A4565) Reimbursement
- 600-1801 – Claims Submission Guidelines and Rental Timeframes for Nebulizers
- 600-1802 – Claims Submission Guidelines and Rental Timeframes for TENS Devices
- 600-1803 – Claims Submission Guidelines and Rental Timeframes for Wheelchairs
- 600-1804 - Claims Submission Guidelines for an Osteogenesis Stimulator
- 600-1805 - Claims Submission Guidelines for Speech Generating Devices

**Ear, Nose and Throat Services**

The Alliance will reimburse for outpatient ear nose and throat (ENT) procedures without the need for an Authorization Request (AR); as long as the services are performed by an In Service Area or Local Out of Service Area contracted ENT physician and the correct codes and billing processes are used.

An In Service Area Provider is any provider based in the Alliance’s Service Area, regardless of contract status. A Local Out of Service Area Provider is a specialist physician, hospital or allied provider based in an area adjacent to the Service Area, with whom the Alliance has contracted based on an existing referral pattern and claims payment to the provider, and the need for access to the provider’s specialty type.

**Procedures**

A referral from the member’s PCP will be required unless the member is an Administrative Member.

Use the following CPT codes when billing for ENT services: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42860, 69424, 69433, 69436, 69440, 69440, 69450, 69631.
CCS review referral required for the following CPT codes: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42860, 69424, 69433, 69440, 69450.

CCS referral exception to the following CPT codes only: 69436 and 69631.
ECG Services

The Alliance will reimburse for outpatient ECGs without the need for a referral, as long as the services are performed by in an In Service Area or Local Out of Service Area contracted cardiologist (provider specialty 06), radiologist (provider specialty 30), or pediatric cardiologist (specialty 35) and the correct codes and billing process are used.

Specified ECG services will be covered when place of service 21 and/or 22 are billed in conjunction with ECG readings. No referral is required.

Use the following CPT codes when billing for ECG services:

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Emergency Room Casting or Treatment

Referral will not be required for Alliance members who are referred by the emergency room to an orthopedic surgeon within the Alliance in-service and local –out of service area, for casting or treatment of bone fracture, including sprains and strains when services are billed with Diagnosis Code Ranges: M84-M8468XS, S02-S0292XS, S12-S129XXS, S22-S229XXS, S32-S329XXS, S42-S4292XS, S52-S5292XS, S62-S6292XS, S72-S7292XS, S82-S8292XS, S92-S92919S, T148, S93- S93699S.

Fecal Occult Blood Testing

The Alliance will authorize payment for fecal occult blood testing that is part of routine screening examination to rule out colorectal cancer in members between age 50 and 75. Billing code: 82270

Hearing Aids

The Alliance covers hearing aids when supplied by a hearing aid dispenser, the prescription of an otolaryngologist or the attending physician when no otolaryngologist is available in the community. An audiological evaluation, including a hearing aid evaluation performed by, or under the supervision of, the above prescribing physician, or by a licensed audiologist, is required. Prior authorization is required for the purchase or rental trial period of hearing aids and for repairs that cost more than $25 per repair service. The following CPT/HCPCS codes related to hearing aids will not be capped annually:

V5014;V5264;V5265;V5030;V5040;V5050;V5060;V5070;V5080;V5298;V5120;V5130;V5140;V5150;V5170;V5180;V5190;V5210;V5220;V5230;V5267.
Mileage Cost Reimbursement for Travel to Repair Wheelchairs/Scooters

The Alliance will cover mileage costs incurred by a provider when he/she goes to and from an Alliance member’s home to repair wheelchairs/scooters.

Procedure code X2999 is an Alliance-only benefit that allows reimbursement for mileage when a provider goes to and from a member's home to make wheelchair repairs.

- Reimbursement is $0.32 per mile.
- X2999 falls under the same guidelines for Authorization Requests as repairs — i.e., an AR is required only if maintenance or repair (and/or travel) exceeds $500 (cumulative cost of related items within a group).
- This applies to Alliance primary members and Medicare/Alliance members only.

DME Serial Numbers

Providers will be required to include DME serial number notation when filing a claim for the following items: Concentrators and Ventilators, Speech Generating Devices, Hospital Beds, Wheelchairs and accessories, Lift Devices and accessories.

Miscellaneous Policies and Instruction

600-1001 - Claims Processing
600-1009 - Corrected Claim Submissions
600-1010 - Miscellaneous Drugs and Medical Supplies
600-1011 - Surgical Implantable Devices Z7610
600-1013 - Postoperative Pain Management
600-1015 - National Correct Coding Initiative
600-1016 - Non-Covered Service Billed with a GY Modifier to Medicare
600-1017 - Provider Inquiry and Dispute Resolution
600-1018 - Modifier Placement
600-1019 - Modifier 99 (Multiple Modifiers Not Recognized)
600-1030 - Reimbursement for Medicare Medi-Cal Crossover Nephrology and Dialysis Services
600-1031 - Twins Delivery Reimbursement
600-1036 - Modifier Reference Grid
600-1037 - Global Surgery
600-1039 - Billing for Time Based Anesthesia Services
600-1040 - Unbundled CPT Codes 69210 and 92557
600-1041 - Medicare and Coordination of Benefits Reimbursement
Section 10. Claims

600-1043 - CHDP Program Reimbursement for Snellen Test

600-1044 - H0049 and G0442 CHDP Program for Alcohol Misuse Screening

600-1046 - Contraceptive Products and Services

600-1047 - Place of Service 20 (Urgent Care) [http://www.ccah-alliance.org/providerspdfs/pm/20200101/600-1047-POS-20-Urgent-Care] Billing Location Expansion

600-1048 - Manual Pricing of a Service When There is No Medi-Cal Rate

600-1072 – AB 72

Contraceptives A4267, A4268, A4269U1, A4269U2, A4269U3, A4269U4

When billing for contraceptives using the above codes, please bill by adding the total quantity dispensed in box 24G (Days or Units) of the CMS form or box 46 (Serv Units) of the UB04 claim form. Please note this process differs from Medi-Cal guidelines that instruct providers to bill with a quantity of 1 and then to add the description, quantity dispensed and at cost expense of the item to Remarks.

MMRV Vaccination

For Alliance Care IHSS members, this vaccination combines the attenuated virus MMR (measles, mumps, rubella) vaccine with the addition of the chickenpox vaccine (varicella).

- Providers billing for services rendered to non-Medi-Cal members should bill the MMRV using vaccine CPT code 90710.
- Each claim must be submitted with an invoice.
- These claims will be reimbursed at invoice cost plus an additional 5%.
### Occupational and Speech Therapy Codes

The following CPT codes are to be used for claims submission:

**Occupational Therapy: Billing Codes and Reimbursement Rates (occu cd)**

**Speech Therapy: Billing Codes and Reimbursement Rates (speech cd)**

<table>
<thead>
<tr>
<th><strong>Occupational Therapy Codes (if CPT criteria met)</strong></th>
<th><strong>Speech Therapy Codes (if CPT criteria met)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>X4100 Medi-Cal claims only Evaluation – initial 30 minutes, plus report</td>
<td>92507 Medi-Cal and Commercial claims Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</td>
</tr>
<tr>
<td>X4102 Medi-Cal claims only Evaluation – each additional 15 minutes, plus report</td>
<td>92508 Medi-Cal and Commercial claims Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals</td>
</tr>
<tr>
<td>X4110 Medi-Cal claims only Occupational Therapy - Treatment - Initial 30 Minutes</td>
<td><strong>Facilitated Communication:</strong> There are no specific codes for facilitated communication</td>
</tr>
<tr>
<td>X4112 Medi-Cal claims only Occupational Therapy - Treatment - Each Additional 15 Minutes</td>
<td><strong>Altered Auditory Feedback Devices:</strong> There are no specific codes for altered auditory feedback devices</td>
</tr>
<tr>
<td>97140 Medi-Cal and Commercial claims Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97535 Medi-Cal and Commercial claims Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes</td>
<td></td>
</tr>
</tbody>
</table>
Physical Therapy Codes

The following CPT codes are to be used for Medi-Cal and commercial lines of business claims submission.

Do not use the billing codes in the Medi-Cal Manual.

Please note:

- X codes will not be accepted for claims or authorization submissions.
- Failure to use the appropriate modifier when billing physical therapy codes may result in denial of the claim.

<table>
<thead>
<tr>
<th>Physical Therapy Codes for Medi-Cal Lines of Business (if CPT criteria met)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>99243</td>
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Refractive State Services Used for Claims Payments

Determination of refractive state includes determination of visual acuity with corrective lenses. It is usually performed with an instrument called a phoropter. While looking at an eye chart through the phoropter, the ophthalmologist adjusts the lenses until the chart appears the clearest possible.

Medi-Cal

Non-refractive services billed by ophthalmologists are potentially payable by the Alliance when billed with a primary medical diagnosis.
• Non-refractive services billed by approved optometrists are potentially payable by the Alliance when billed with a primary medical diagnosis.

• A referral is required from the member’s PCP if the Alliance is the primary payer and the referring provider is within the Alliance’s in-service area or local out of service area.

• An authorized referral is needed from a member’s PCP if the Alliance is the primary payer and the referred to provider is out of the service area.

For information on how to become an approved optometrist, please reference Policy 300-4160 Optometrists Reimbursement for Medical Services.

Wheelchair Evaluations

The Alliance will reimburse for wheelchair evaluation to help identify the wheelchair that best fits the members need. The evaluation can be requested by member, medical professional or Alliance staff.

Referral is required for evaluation by local qualified Network PT or Physiatrist and may be reimbursed when billed using one of two Billing Codes:

• X2995: Simple wheelchair evaluation
• X2997: Complex wheelchair evaluation

Evaluation by contracted DME Evaluator may be requested by DME provider, Alliance staff or provider. Referral is not necessary.

Information about Electronic Transactions

To expedite claims processing, the Alliance offers an electronic claims submission service for its providers. This section is designed to provide you with broad understanding of Electronic Data Interchange (EDI) transactions, and serves as a guide to the electronic claims processing at the Alliance.

What is EDI?

EDI refers to the structured transmission of data between organizations by electronic means. Organizations that send or receive documents between each other are referred to as “trading partners” in EDI terminology. The trading partners agree on the specific information that is to be transmitted and how it should be used.

Benefits

There are many benefits to sending your claims electronically to the Alliance, including:

• Decreased data entry errors > Faster payment.
• Reduced paper claim costs > No paper claims to print.
• Lower print costs > No ribbon or toner expense.
• Reduced mailing costs > No envelopes or stamps to buy.
• Decreased office costs > No overhead to print, sort, stuff and mail claims.
• Increased staff efficiency > Quicker claims turnaround time.
Acceptable Transaction File Formats

The Alliance accepts ANSI X12 HIPAA mandated compliant transactions.

For more information on HIPAA, please see the Wedi-Snip website and the Accredited Standards Committee website. If you are interested in submitting electronic claims, please complete, sign and return the EDI Claims Enrollment form to edisupport@ccah-alliance.org. Please contact the EDI Support Team for more information at edisupport@ccah-alliance.org.

Note: If you are interested in submitting electronic claims, please complete, sign and submit the completed EDI Claims Enrollment form to edisupport@ccah-alliance.org.

Clearinghouses

The Alliance can receive EDI files directly using a Secure File Transfer Protocol (SFTP) or through any clearinghouse.

The Alliance is currently affiliated with the following clearinghouses:

Office Ally
Contact Office Ally customer service at (866) 575-4120 or email info@officeally.com.

Payer ID is CCA01 (Professional and Institutional)

Change Healthcare
Contact Change Healthcare enrollment group at (866) 924-4634 or email PayerContact@changehealthcare.com

Payer ID is SX169 (Professional); 12K82 (Institutional)

ClaimRemedi
Contact ClaimRemedi enrollment group at (800) 763-8484 x3 or email enrollment@claimremedi.com Payer ID is 95311 (Professional and Institutional).

If providers choose to work with Office Ally, they can submit claims at no charge. Please email the Alliance EDI Support Team at edisupport@ccah-alliance.org for further details. Provider Relations Representative

Acceptable File Formats

The Alliance accepts and transmits ANSI X12 HIPAA mandated compliant transactions.

For more information on HIPAA, please see the Wedi-Snip website and the Accredited Standards Committee website. If you wish to implement Electronic Claims Payment, Electronic Remittance Advice (835), or any other HIPAA mandated transactions, please complete, sign and submit the EDI Trading Partner Agreement to edisupport@ccah-alliance.org.
Support

The Alliance EDI Unit can be reached directly at edisupport@ccah-alliance.org or by calling (800) 700-3874 ext.5504.

Frequently Asked Questions about Claims

9. Does the Alliance follow the same timeliness guidelines as Medi-Cal?
   Yes. For our Medi-Cal lines of business, the Alliance follows Medi-Cal Timeliness and Delay Reason Codes guidelines. Please see the Medi-Cal Provider Manual for further information.

10. How do I interpret information on the Alliance Remittance Advice (RA)?
    Please refer to the Alliance Remittance Advice Guide available on our provider website.

11. Will the Alliance accept electronic claims?
    Yes. The Alliance accepts and encourages electronic claims submission. If your practice or facility is interested in having your Alliance claims processed electronically, please contact our EDI Support Unit by emailing a completed EDI Claims Enrollment form to edisupport@ccah-alliance.org.

12. When and how should I follow-up on claims possibly held for processing by the Alliance?
    Please consider the date the claim was mailed in estimating if follow-up or a request to re-bill is appropriate. Claims are processed based on the date of their receipt at our office. For most practices, the appropriate timeframe for follow-up would be 45 calendar days after the claim was originally mailed. We suggest that providers use the electronic tracking of claims available through our Provider Portal Services or call the Claims Customer Service Representative line Monday - Friday, 9:00 AM - 4:00 PM at (800) 700-3874 ext. 5503.

13. Can previously denied claims be resubmitted via the web?
    Contracted providers may use the Provider Portal to search for claims and resubmit previously denied claims. If your office is not set up to use our Provider Portal, please contact your Provider Relations Representative for instructions on how to set up an account.

14. What form should I use to bill Child Health and Disability Prevention (CHDP) Program claims?
    CHDP services performed with a date of service on or after January 1, 2018 must be billed using the CMS or UB claim forms or equivalent electronic claim transactions. PM 160 forms for services rendered on January 1, 2018 or after will not be accepted.
    CHDP claims for services prior to January 1, 2018 were billed on a PM-160 form.
    The Alliance will return any incomplete PM-160 forms to the provider before processing; therefore, please follow the CHDP guidelines provided by the state of California. Please visit the DHCS website and select “Programs” then “CHDP Manual and Bulletins” for complete information on the CHDP Provider Manual and program.
Note: Services rendered to Alliance Care IHSS members should be billed on CMS/UB04 forms using standard commercial insurance billing guidelines, as these programs are not applicable to CHDP or Medi-Cal. Non-CHDP Providers should bill using the CMS or UB-04 forms.

15. How should claims for newborns be submitted?

Services rendered to an infant in the month of birth and the month following birth may be billed under the mother’s Alliance ID number as a Mom/Baby claim following Mom/Baby claim guidelines. A referral for services is not required during this timeframe. After this timeframe, the infant must have their own Alliance ID number.

- To bill correctly on the CMS form, ensure that the mother’s Alliance ID number is in field 1A, the infant’s name is in field 2, the infant’s birth date is in field 3, and the Child box is checked in field 6.

- To bill correctly on the UB 04 form, ensure that the infant’s name is in Box 8B, the infant’s date of birth and sex are in Boxes 10 and 11, the mother’s name is in Box 58, “03” (CHILD) is in Box 59, and the mother’s Alliance ID number is in Box 60.

16. How does the Alliance process claims for children eligible for California Children’s Services (CCS)?

Claim for dates of service prior to 7/1/18:
Original claims billed with a CCS diagnosis and/or a CCS-eligible condition will be denied.

A denial will also appear on a subsequent remittance advice. The outcome of the Alliance’s review of potential CCS claims centers on the diagnosis listed by the provider’s office. Some offices have billed non-CCS claims, resulting in slow payments or inappropriate denials.

Claims for dates of service after 7/1/18:
The Alliance will process CCS claims, with a few exceptions that are billed to State Medi-Cal.

Claims submitted to Alliance should include the CCS diagnosis code on the claim when treating the member for the CCS condition. Prior authorization is required – see Health Services Policy 404-1305_Screening_and_Referral_of_Medically_Eligible_Children_to_California_Childrens_Services_CCS_Program.

Since the Alliance has not changed the Medi-Cal coding/billing requirements from those required by Medi-Cal, you may use the Medi-Cal Provider Manual as your Alliance billing guide.

17. How should I handle Share-of-Cost (SOC) collection and billing?

Share-of-Cost (SOC) collection and billing is an important function for every provider’s office. The Point of Service (POS) device or Automated Eligibility Verification System (AEVS) at (800) 456-2387 will inform you of a member’s outstanding SOC and allow you to clear the amount collected (or the amount that the member is obligated to pay). Members with outstanding SOC amounts are not eligible to receive services under their Alliance membership until the SOC is collected and cleared. Once the amount collected (or the amount obligated) is cleared, the Alliance member will be eligible to obtain services (or will be closer to being eligible to obtain services if there is a remaining SOC
amount). It is important for all providers to collect and clear SOC each month to ensure a member’s ability to obtain services from other providers later that month.

Once a SOC has been collected, the Alliance will compute the Medi-Cal allowance and subtract the amount already paid by the member. If the member’s payment exceeds the Medi-Cal allowance, then the Alliance reimbursement will be $0 (in such a case, you would not need to bill the Alliance for the services because you will have been paid more than Medi-Cal allows). If the member’s payment is less than the Medi-Cal allowance, then the net reimbursement will be the difference.

- **CMS claim form:** Enter the amount collected (or obligated) in box #10d of the CMS claim form. The amount collected (or obligated) should also be entered in box #29 and should be subtracted from the total balance due (box #30).

- **UB-04 claim form:** Enter code “23” and the amount of the patient’s SOC in box 39. In box 55 enter the difference between “Total Charges” (box 47) and SOC collected.
18. How are refunds or reversals/take backs processed?

**Alliance Identified Overpayment:**

Research is completed by Alliance staff to identify overpayments on claims. Overpayments may have been made due to a duplicate claim payment, lack of coordination of benefits with the member’s primary health care insurance policy or incorrect billing procedures. When an overpayment is identified, the Alliance will mail a notification of overpayment to the provider requesting a refund.

**Provider Identified Overpayment:**

If a provider’s business office identifies an overpayment, they are required to report when they received an overpayment, to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Alliance in writing of the reason for the overpayment. Providers may fill out the Provider Identified Overpayment form that can be found in the Finance section of the Form Library of the Alliance website.

The provider should issue a refund check payable to:

Recoveries Department  
Central California Alliance for Health  
1600 Green Hills Road, Suite 101  
Scotts Valley, CA 95066-4981  

Please include the refund check with the Financial Control Number (FCN), date of service of the claim overpayment, patient’s member ID number, reason for the refund and the claim number so that the recovery can be recorded to the proper account.

Alternatively, some providers prefer that recoveries are made electronically. If an electronic refund or reversal of an overpayment is preferred, please notify Recoveries staff at (800) 700-3874, ext. 5622 or send an e-mail to recoveriesadmin@ccah-alliance.org.

19. What do I do if I disagree with how a claim was paid or denied?

Providers may disagree with how a claim was priced/paid or whether or not it was denied appropriately. These issues can often be handled directly by the Claims Department without the involvement of Provider Services or Health Services departments. Please contact an Alliance Claims Customer Service Representative Monday - Friday, 9:00 a.m. - 4:00 p.m. at (800) 700-3874 ext. 5503.

In situations where you disagree with the Claims Department decision after calling, please contact your Provider Relations Representative who will evaluate the issues. For further information, please refer to the Alliance Provider Manual, Section 17, Resolution of Disputes and Grievances.

20. When can I bill an Alliance member for an unpaid service?

You may not bill an Alliance member for any unreimbursed amount, including a deductible/co-insurance or copay amount, unless one of the following exceptions applies:

- The member has an unmet monthly Medi-Cal share-of-cost amount.
• The member does not disclose their Alliance/Medi-Cal coverage.
• The member consents to receive services that are not covered by the Alliance.
• The member chooses to see a physician/provider who does not accept Medi-Cal or is not a Medi-Cal provider.
• The member waives their Medi-Cal benefits.
• The member does not obtain or access primary insurance benefits correctly.

Note also that, unless you have provided benefits to the member according to the primary insurance authorization/benefit requirements, you may not charge the Alliance member for the service.

21. Claim forms completion guidelines

All forms must be 8 ½ x 11 inches. Undersized attachments need to be taped to an 8 ½ x 11-inch sheet of white paper. The Alliance retains electronic images by using a scanner. The scanner does not accept anything other than a full sheet of 8 ½ x 11 paper.

• Do not staple or fold claims, and please use mailing envelopes that do not require you to fold your claims. During claims processing, all staples must be removed, and folded claims must be unfolded and smoothed flat before entering the scanner. These time-consuming tasks slow the process.

• Do not highlight information. When the form and attachments are scanned, the highlighted area will show up only as a black mark, obscuring the highlighted information. The result will most often be a denied claim.

• Do not strike over errors or use correction fluid. Cover incorrect data using correction tape and re-enter the correct information. All claims must be legible and dark enough for scanning.

• All hardcopy claims must be signed or initialed by an authorized staff person in your office unless there is an electronic signature waiver.

• Please bill all claims using the Alliance member ID number. The recipient’s Alliance ID number, name (do not abbreviate), gender and the date of birth entered on the claim must match the information on the Alliance recipient’s card. The “-01” at the end of the Alliance ID number is not required. It is not necessary to submit a Point of Service (POS) device printout as a claim attachment. Please do not use the fourteen-digit Medi-Cal identification number.

A quantity for each service rendered is required. Please enter quantities as a single digit (e.g., “1” not “01,” “001” or “010”). Also, please do not include negative quantities.

22.

Billing Requirements for Hospital Inpatient Services: Statement Dates
In order to comply with Department of Health Care Services (DHCS) requirements, inpatient claims must only bill for services dated within the statement date. Codes dated prior to or after the statement date are billing incorrectly.

Codes that need to fall on or within the statement dates include: occurrence, principle procedure and other procedure. If the date of any code billed does not fall between the statement period dates, the claim is incorrectly completed. See correct hardcopy UB-04 claim form examples below.

- **UB-04 Hardcopy, Field 6: Statement Covers Period**
  Enter the beginning and ending service dates of the entire period covered in the claim in MMDDYY format. For services provided on a single day, enter the date of service as both the “from” and “through” date. Any other codes submitted on the claim need to fall on or within the statement covers period dates.

- **UB-04 Hardcopy, Fields 12-13: Admission / Start of Care Date and Admission Hour**
  Enter the date of admission for inpatient services. Enter in MMDDYY format. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day; this should not be altered.

  Enter the admit hour as follows: Eliminate the minutes and convert the hour of admission/discharge to 24-hour (00 – 23) format (for example, 3 p.m. = 15)

- **UB-04 Hardcopy, Fields 31-34: Occurrence Codes and Dates**
  Enter the code and associated date noting a significant event relating to the claim that may affect payer processing.

- **UB-04 Hardcopy, Fields 35-36: Occurrence Span Codes and Dates**
  Enter the code and the related dates that identify an event relating to the payment of the claim.
**UB-04 Hardcopy, Field 74: Principal Procedure Code and Date**
The ICD-10-CM code for the principal procedure and date performed.

**UB-04 Hardcopy, Fields 74a – 74e: Other Procedure Codes and Dates**
Enter the ICD-10-CM procedure codes and dates for up to 5 additional procedures.
The Alliance Care Management (CM) team works with members to provide services and supports to improve and/or maintain health and quality of life. CM services include: complex case management for adults and pediatric members, care coordination, and preventive health education, including chronic disease self-management.

The CM multidisciplinary team consists of experienced nurses, medical social workers, care coordinators, and health educators, who collaborate with the PCP and specialty providers to provide coordinated care through the Patient Centered Medical Home (PCMH). The team’s main focus is to improve quality of life through the promotion of realistic self-care goals and management of chronic health conditions. CM services are voluntary and available to all eligible Alliance members at no cost to them. Members who do not wish to participate in the program can opt out at any time.

The team works with members and their PCPs by:

- **Facilitating** safe connections between the PCP and the member
- **Educating** members on a variety of health-related topics, including appropriately navigating the health care and social systems
- **Empowering** members to take charge of their own health care needs
- **Linking** members to available community resources

### Complex Case Management

The Alliance Complex Case Management team partners with the PCP and specialists to support members in managing their acute or chronic condition(s). This may include intense coordination of resources from the multidisciplinary team to ensure the member regains optimal health or improved functionality. Individualized person-centered care plans are created with the involvement of the care team and member. The support may include services that address emotional, physical, and social support needs.

The Complex Case Management Team collaborates with you as the PCP to provide the following services:

- Comprehensive assessments
- Promotion of the PCMH by fostering the member-PCP relationship
- Care coordination
- Promotion of self-management through engagement
- Linkage to community and social support resources
- Creation of mutually-agreed upon care plans, including targeted interventions
Section 11. Care Management Services

- Engagement of members telephonically and in-person
- Support across the health care continuum

What is suitable for referral to Complex Case Management Services? *(Note: this is not an all-encompassing list):*

<table>
<thead>
<tr>
<th>Chronic Illness</th>
<th>Catastrophic Diagnosis</th>
<th>Medical Issues</th>
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<tbody>
<tr>
<td>Poorly-controlled chronic illness or new/worsening complications (i.e. asthma and diabetes)</td>
<td>Complex injuries</td>
<td>Complicated wounds</td>
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<tr>
<td>Obesity/bariatric patients</td>
<td>HIV/AIDS (new diagnoses and unlinked)</td>
<td>Stroke with complications</td>
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<tr>
<td>Medication reconciliation</td>
<td>End-of-life</td>
<td>New or worsening debilitating disease (i.e. Multiple Sclerosis, Parkinson’s Disease)</td>
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<tr>
<td>Multiple hospital admissions (excludes cancer)</td>
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<td>Seizure disorder with complications</td>
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<tr>
<td>Palliative care</td>
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</table>

What is not suitable for referral to Complex Case Management Services? *(Note: this is not an all-encompassing list):*

- Members with other health care coverage
- Members with disruptive, violent, or abusive behaviors
- Members who are unable to be reached or who refuse to participate
- Members in long-term care

**Basic Case Management**

Basic Case Management is provided by PCPs. Case Management, as defined by the California Department of Health Care Services (DHCS), is “guiding the course of resolution of a personal medical problem (including the problem of the need for health education, screening or preventive services) so that the recipient is brought together with the most appropriate provider at the most appropriate times, in the most appropriate setting.” It is essentially a program that enables providers and caregivers to identify members with ongoing health care needs, so that an effective plan may be developed that enables the efficient use of health care resources -- with a goal of achieving the best possible health outcomes.

Four requirements are necessary for the basic case management system to function:

- Members receiving basic case management must be assigned to a PCP.
Through prior authorization, PCPs will refer members directly to all necessary services, with the exceptions of Emergency, Limited Allied Services (Medi-Cal line of business only), OB-GYN and certain family planning services that qualify for self-referral.

PCPs in either individual or group practice — and in private and/or public settings — will be geographically located throughout Santa Cruz, Monterey and Merced counties to facilitate members' access to health care services.

The objectives of a good case management plan are:

- To foster continuity of care – as well as good relationships – between providers and members.
- To coordinate the care of Alliance members so that satisfactory health outcomes are achieved.
- To contribute to a decreased use of hospital ERs as a source for non-emergency, first contact and urgent medicine by our members.
- To reduce the incidence of members’ unnecessary self-referral to specialty providers.
- To discourage medically inappropriate use of pharmacy and drug benefits by our members.
- To facilitate members’ understanding and use of disease-prevention practices and early diagnostic services.
- To provide a structure within which our providers can manage members’ health care services in a manner that ensures a high quality of care delivered in a cost effective manner.

For complete details on physician case management responsibilities, please see Policy 404-1313 - Primary Care Provider Responsibilities in Case Management and the Promotion of Primary Care Medical Home.

**Care Coordination**

The Care Coordination Team assists members with less complex, non-clinical needs by providing:

- Referrals and coordination with community resources and services, including other Case Management programs, Local Education Agencies, Regional Centers, etc.
- Follow-up care with specialists, including referrals for ancillary services and Durable Medical Equipment (DME)
- Assistance with making appointments and retrieval of medical records
- Appointment reminders and linkage to transportation resources

For information or referrals to Care Management Services, including Complex Case Management and Care Coordination, please call the Case Management Line at (800) 700-3874 ext. 5512.
Case Management Support for Members with Disabilities or Special Needs

Children with Special Health Care Needs
The Alliance pediatric Case Management team helps members and their parents/guardians with obtaining the care and services that are needed. Case Management and Care Coordination support are offered to all members who are enrolled in the CCS program.

For more information on children with special health care needs, please see Policy 405.1106 - Children with Special Health Care Needs (CSHCNs).

Individuals with Disabilities
The Case Management team coordinates services and helps members obtain the equipment they need.

Members with Developmental Disabilities: Medi-Cal
During the Initial Health Assessment performed when enrolling new children into your practice, providers will identify those who have, or are at risk of acquiring, developmental delays or disabilities; this includes signs and symptoms of intellectual disability, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability. Additionally, developmental screening is a part of each well-baby and well-child visit.

A developmental disability is a disability attributable to an intellectual disability, cerebral palsy, epilepsy, autism, or other conditions similar to an intellectual disability that originates before the age of 18 years, is likely to continue indefinitely, and constitutes a significant handicap for the individual. A developmental delay is impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

The Alliance is required to cover all medically necessary and appropriate developmental screenings, primary preventive care, diagnostic and treatment for members who (a) have been identified or are suspected of having developmental disabilities; and (b) are at high risk of parenting a child with a developmental disability. The Alliance works to ensure that members with developmental disabilities receive all medically necessary screening, preventive, and therapeutic services as early as possible and determines medical necessity for covered services.

Such members are referred to the appropriately funded agency, such as the Local Education Agencies (LEA), the San Andreas Regional Center (SARC) in Santa Cruz and Monterey Counties, and the Central Valley Regional Center (CVRC) in Merced County. SARC and CVRC are part of a statewide system of locally-based regional centers that offer supportive services programs for California residents with developmental disabilities. Regional centers provide intake and assessment services to determine client eligibility and needs and work with other agencies to provide the full range of early intervention services. Local regional centers can provide specific information on the services available in the member’s service area. Services include respite day programs, supervised living, psychosocial and developmental services, and specialized training.

Members with developmental disabilities are linked to a PCP, who provides them with all appropriate preventive services and care, including necessary Early Periodic Screening, Diagnosis, and Treatment...
(EPSDT) services. Preventive care is provided per the current guidelines of the American Academy of Pediatrics and the United States Preventive Services Task Force for Adults. PCPs are required to provide or arrange for medically necessary care to correct or ameliorate developmental disabilities and provide/arrange for all medically necessary therapies and items of durable medical equipment within the scope of their practices. For those necessary services that are beyond the scope of their practices, PCPs should make the necessary referrals and coordinate with the appropriate funding agency.

PCPs should collaborate in the development of a child’s IEP (the school district’s Individualized Education Plan), IFSP (the Regional Center’s Individual Family Service Plan), or IPP (the Regional Center’s Individual Program Plan), when applicable. PCPs should monitor and coordinate all medical services with Regional Center Staff, when applicable.

Contact information for the local regional center field offices in Santa Cruz, Monterey and Merced Counties are:

<table>
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<tr>
<th>SARC Santa Cruz Field Office</th>
<th>SARC Monterey Field Office</th>
<th>CVRC Merced Field Office</th>
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<tbody>
<tr>
<td>1110 Main Street</td>
<td>1370 South Main Street</td>
<td>3172 M Street</td>
</tr>
<tr>
<td>Watsonville, CA 95076</td>
<td>Salinas, CA 93901</td>
<td>Merced, CA 95348</td>
</tr>
<tr>
<td>Tel. (831) 900-3737</td>
<td>Tel. (831) 900-3636</td>
<td>Tel. (209) 723-4245</td>
</tr>
<tr>
<td>Fax (831) 728-5514</td>
<td>Fax (831) 424-3007</td>
<td>Fax (209) 723-2442</td>
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</table>

For additional information about patients with developmental disabilities and the use of regional centers, please see the following policies:

Policy 405-1304 - Developmental Disabilities - Services to Plan Members.
Policy 405-1302 - Early Intervention Services.

**Coordination of Care: Medi-Cal and Alliance Care IHSS**

As a PCP, you are part of the interdisciplinary team supporting the member's medical, as well as psychosocial and environmental needs. Screening, preventive, and medically necessary and therapeutic services that are covered benefits will continue to be covered by the Alliance.

The Alliance will continue to provide for normally covered medical services for members receiving services related to CCS, from San Andreas Regional Center (SARC), Central Valley Regional Center (CVRC), or the Early Start Program and will coordinate with the PCP and the designated center to assist with the development of a care plan, or in meeting the care plan that has been developed.

The Alliance maintains Memoranda of Understanding (MOU) with the Santa Cruz County Health Services Agency, Monterey County Health Services Department, and Merced County Department of Public Health. The MOU is an agreement between the Alliance and a division of the county Health Services Agency that delineates how the two entities will coordinate the provision of covered and/or public health services, as appropriate. The MOU also delineates the roles and responsibilities of each agency related to specific public health services.
Health Education and Disease Management Programs

The Alliance is committed to improving access to affordable health care for our members. To accomplish this, the Alliance offers innovative programs to help members achieve healthier outcomes. These programs are managed by a multidisciplinary team comprised of experienced health educators who assist members with techniques to stay healthy and to understand and manage chronic disease/s, including enrollment in the Alliance Health Education and Disease Management Programs. Detailed information about these services is provided in Section 12 and 13 of this manual.

For information or referrals to the Alliance Health Education and Disease Management Programs, please call the Health Education Line at (800) 700-3874 ext. 5580.
Section 12
Disease Management Program

The Disease Management Program is designed to work with members diagnosed with diabetes, asthma, or other chronic health conditions by providing them the necessary self-management tools they need to properly manage their condition/s. The ultimate goals are to improve patients’ current health status, achieve optimal health outcomes, and to avoid future complications of chronic disease/s.

Alliance members with asthma, diabetes and/or other chronic health conditions are identified using administrative, encounter, and pharmacy data. Members can also be referred to these programs by their PCP or other Alliance case management staff, or can self-refer. PCPs are notified about high-risk members via the Provider Portal and other means. High risk members are those with a high incidence of hospitalization and emergency department (ED) usage, those with screening deficiencies and members who have not had PCP contact for more than 12 months. Additionally, we support PCPs by providing clinical practice guidelines, useful clinical forms, and technical assistance as needed.

Health Programs staff work with members to refer them to health education classes, provide them with health education materials and refer them to additional community resources and services that are culturally and linguistically appropriate for the Alliance’s diverse membership. Members also receive letters with basic health information about self-management of their conditions and the importance of regular PCP visits and routine screenings.

**Chronic Disease Self-Management Workshops**

Chronic diseases such as diabetes, asthma and chronic obstructive pulmonary disease require ongoing care and often affect an individual’s overall quality of life. Often these conditions are best managed or avoided through prevention, a combination of clinical services, health education, counseling and community based interventions. Through Stanford University’s Chronic Disease Self-Management Program, the Alliance has implemented the Healthier Living Program; a series of self-management workshops designed to help individuals with chronic conditions build the confidence to manage their health and maintain an active and fulfilling life. Participants can develop self-management skills in an interactive learning environment, sharing experiences with others who have a chronic condition and providing mutual support.

Workshops cover 17 hours of material over a six-week period and are conducted at local and convenient locations in the community. Workshops focus on common problems among individuals suffering from any chronic condition(s) and supports them with:

- Pain management
- Nutrition
- Physical activity
- Medication usage
- Communicating with doctors
Participants who complete the series receive: A book titled *Living a Healthy Life with Chronic Conditions* and an audio CD called *Relaxation for Mind and Body* to assist in their chronic disease self-management. Alliance members who participate in the weekly sessions and who complete all six classes can receive a gift card of the amount of $25. In addition, participants are entered in a raffle to win prizes.

There is no cost for Alliance members to participate. Workshops are conducted in English and in Spanish at convenient locations in the community. Members can be referred to Health Programs by their PCP or other Alliance case management staff, or can self-refer. For more information on how to refer Alliance members to this program or to receive a copy of a current workshop schedule, please call the Alliance Health Education Line at (800) 700-3874 ext. 5580.

**Clinical Health Education Benefits**

The following Clinical Health Education services are covered by the Alliance as an expanded benefit. Please visit the provider website for important information, including required program components, billing and reimbursement guidelines, and the approved providers list. Education providers must be pre-approved by the Alliance to bill for these services. ARs are not required for the basic program, as outlined below; however, ARs may be submitted to request additional services, if medically necessary.

**Asthma Education**

The Alliance covers up to six (6) hours of comprehensive asthma self-management education, including up to four (4) hours of individual training and the remaining hours as group training during the initial twelve-month period after an asthma diagnosis, with up to two hours of follow-up during each subsequent year. Education providers must be pre-approved by the Alliance to bill for these services. Education is provided on an individual or group basis and is delivered and/or supervised by a Respiratory Therapist (RT) or nationally certified Asthma Educator (AE-C). PCPs should include relevant medical history when referring patients and the asthma education provider will contact the member’s PCP when indicated.

**Diabetes Prevention and Self-Management Education**

**Diabetes Prevention Education**

Members of any age diagnosed with pre-diabetes can participate in diabetes prevention education for up to 16.5 hours of group training during the initial twelve-month period. These services are provided through Alliance-approved pre-diabetes education providers, which use an evidence-based curriculum for pre-diabetes education and who can bill for these services. Members can be referred by their PCP or other Alliance case management staff, or can self-refer.

**Diabetes Prevention Program (DPP)**

The DPP program covers a minimum of 22 DPP sessions for the first 12 months of the DPP benefit. These services are provided through Alliance-approved DPP education providers who can bill for these services. The DPP is an evidence-based lifestyle change program, taught by peer coaches, designed to prevent or delay the onset of type 2 diabetes among individuals (ages 18 and older) diagnosed with prediabetes. The DPP is taught in a classroom setting in a small group, participants learn about healthier eating, physical activity and other behavior changes. This is a year-long program. Alliance-approved DPP providers must meet the Centers
for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) and be enrolled in the Medi-Cal Program with DHCS. Please visit the DHCS website for important information, including required Medi-Cal program components. Members can be referred by their PCP or other Alliance case management staff, or can self-refer.

**Diabetes Self-Management Program (DSMP)**

Up to 20.5 hours (4 hours of individual training and up to 16.5 of group training) of Comprehensive Diabetes Self-Management Education is covered during the initial twelve-month period after diagnosis, with up to two hours of follow-up during each subsequent year. Education providers must be pre-approved by the Alliance to bill for these services. Education is provided on an individual or group basis and is delivered by a physician, Certified Diabetes Educator or by a Registered Nurse or Registered Dietitian who meets specific criteria. Physicians should include relevant medical history when referring patients and the diabetes education provider will contact the member’s PCP when indicated. Members under 21 years of age should be referred to a CCS-approved Special Care Centers (SCC) for coordination of diabetes care including education by a CCS paneled provider, as appropriate.

For more information on Diabetes Prevention and Self-Management Education services, please refer to the benefit description on the provider website or call the Alliance Health Education Line at (800) 700-3874 ext. 5580.

**Breastfeeding Support**

The Alliance gives new moms access to breastfeeding education, support, and free to low-cost community resources. The Alliance breastfeeding support benefit covers:

1. Two hours with an International Board Certified Lactation Consultant (IBCLC), outside the hospital stay, when medically necessary (inpatient lactation education is included in the hospital per-diem). The IBCLC will assist the member with complex problems, such as mastitis, suppressed lactation, etc., and must be pre-approved by the Alliance to bill for services.

2. Members can access a breast pump at no cost to them if either mom or baby has medical issues that prevent nursing at the breast (when medically necessary), or if the mother is returning to work or school and wants to continue breastfeeding. Alliance members are eligible for one personal use breast pump every three years. If there is a need for a second breast pump during the three-year period, an Authorization Request must be submitted with documentation stating the reason that the original pump cannot be used.

3. Replacement breast pump supplies, effective November 1, 2018, in accordance with the DHCS, a Treatment Authorization Request (TAR) must be submitted justifying the need for any breast pump supplies for DME to be replaced. The following HCPCS for breast pump supplies codes require a TAR: A4281, A4282, A4283, A4284, A4285, and A4286. Theses codes may not be reimbursed when provided within the same month of service as a breast pump codes E0602 and E0603. Breast pump supplies can be ordered as a replacement part. This would not have any impact on the breast pump with original supplies- those would continue to be available without prior authorization if member meets breast pump eligibility criteria.

4. Up to one visit per day with a home health nurse from a contracted home health agency is covered for common breastfeeding problems and routine postpartum care. A TAR is required.
Section 13
Health Education Programs

The Alliance offers a large variety of culturally and linguistically appropriate health education programs to all Alliance members at no charge. The following is a brief description of the health education benefits and programs offered by the Alliance. Please visit the Alliance Health Education and Disease Management Program page of the Alliance provider website for important information, including required program components, program eligibility, and member incentives information. Providers and members may also call the Alliance Health Education Line at (800) 700-3874 ext. 5504 for more information.

Health Education Programs

Weight Management Education

Healthy Weight for Life: Adolescent Weight Management: An Alliance program designed to engage with members who are identified as high risk and are contacted by Alliance staff, who utilize motivational interviewing techniques to assist members and their families in identifying measurable goals that support the adoption of a healthier lifestyle. Members who are lower risk do not receive direct contact, but all participating members receive health education materials via mail. These materials emphasize the importance of nutrition and physical activity, and provide an overview of available local low/no cost exercise and nutrition resources.

Wellness that Works Support (formerly Weight Watchers)- Adult Weight Management: The Alliance has a limited number of scholarships available to provide vouchers for eligible members to attend Wellness that Works. Members with significant obesity-related morbidities and a commitment to sustained lifestyle change will be the highest priority. This program is a weight management program that is not a Medi-Cal benefit, but an Alliance benefit. Members must be referred by their PCP. The PCP can complete an application on the member’s behalf and agree to follow-up with the member for medical management of their weight loss.

Eligibility:

- Only members with Alliance as their primary insurance are eligible for the scholarship.
- Members must have a BMI of 30 or above.
- Members must be at 18 years of age or older to be considered.
- Members who are referred and are under the age of 18 will be assessed on a case by case basis for special consideration. The application form must include a weight goal provided by the Primary Care PCP. Please note that the Alliance also offers the Healthy Weight for Life Program for members’ ages 2-18.

Perinatal Health Education

The Healthy Moms and Healthy Babies (HMHB) program is designed to encourage pregnant women to seek early prenatal and postpartum care, and to provide education to support a healthy pregnancy. Members enrolled in the Early Prenatal Care program are contacted by Alliance Health Educators, who provide
educational materials on a variety of topics, including breastfeeding, pediatric care, prenatal and postpartum health, and parenting. Members also receive referrals to local resources, including Women, Infants and Children (WIC) and free or low-cost community resources.

**Breastfeeding Support and Breast Pump Benefit**

Members are given access to breastfeeding education, lactation support, and free or low-cost community resources. Mothers are eligible for a breast pump at no cost to them if either mother or baby has medical issues that prevent nursing at the breast (when medically necessary), or if the mother is returning to work or school and wants to continue breastfeeding. We encourage the use of these benefits to members to promote the health of the child and the mother, as well as to foster the bond that occurs between mother and child during breastfeeding. For more information on breastfeeding support and breast pump services, please refer to the Breastfeeding Support and Breast Pump Benefit Description on the Health Education and Disease Management of the Alliance provider website.

**Tobacco Cessation Support Program**

The Alliance is committed to supporting members who wish to stop smoking and/or using tobacco products. To accomplish this, the Alliance provides tobacco cessation benefits and services that support the prevention and cessation of tobacco use. The Tobacco Cessation Support Program (TCSP) offers many ways to help members quit smoking or using any tobacco products. Members are referred to the convenient, toll-free California Smokers' Helpline at 1-800-NO-BUTTS (1-800-662-8887), which provides free cessation counseling over the phone for anyone in California. The Alliance will also cover the cost of counseling sessions for eligible Alliance members. In addition, the Alliance will cover all FDA-approved tobacco cessation medications for adults who smoke and/or use other tobacco products (non-pregnant adults of any age). For more information on this program, please refer to the Tobacco Cessation Benefit Description on the Health Education and Disease Management page of the Alliance provider website.

**Women’s Health**

The Alliance encourages providers to perform routine screening for chlamydia, cervical cancer and breast cancer, as well as to educate women on the importance of routine breast self-exams. The Alliance provides monthly and quarterly reports via the Provider Portal to assist in monitoring women who may be due for these screenings.

**Patient Education Materials**

In addition to the extensive array of programs described above, the Alliance provides free samples of health education materials that can be given to Alliance patients. Materials are suitable for low-literacy readers and are culturally and linguistically appropriate for the Alliance’s membership. Materials are readily available in English and Spanish; materials in Hmong, Braille, large font and audio files can be made available upon request. For assistance, please contact the Alliance Health Education Line at (800) 700-3874, ext. 5580.

**Materials on Other Topics or In Different Languages**

Depending on the topic and language needed, the Alliance can refer you to materials that are available free on the Internet or to low-literacy materials available for purchase directly from the vendor. The Alliance can
also provide a brief list of translation agencies, should you choose to have your own English materials translated into other languages.

Outreach to Members and Providers

The Alliance reaches out to providers and members on a regular basis to encourage health maintenance, disease prevention, and a healthy lifestyle. Following are some of the tools the Alliance utilizes in the outreach program:

- Living Healthy, quarterly Member Newsletter.
- Health Programs and Cultural and Linguistic updates in the quarterly Alliance Provider Bulletin.
- The provider website with health programs and Cultural and Linguistic services and resources for both providers and members.
- Collaboration with public-health coalitions on outreach programs for breastfeeding, obesity, diabetes, immunization, and other health care issues.
Section 14
Quality and Performance Improvement Program

The Alliance Quality and Performance Improvement Program (QPIP) exists to assure and improve the quality of care for Alliance members, in fulfillment of state and federal requirements, and incorporates various best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) as deemed appropriate.

Quality and Performance Improvement Program Goals

The QPIP provides a comprehensive structure to achieve the following goals:

- Ensure all medically necessary covered services are available and accessible to all members regardless of cultural and ethnic background, race, color, national origin, creed, ancestry, religion, language, age, sex, sexual orientation, gender, gender identity, marital status, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56; and provided in a culturally and linguistically appropriate manner;
- Ensure integration with current community health priorities, standards and public health goals;
- Ensure patient safety;
- Identify and act upon opportunities to address potential quality issues and review trends;
- Identify overuse, misuse and underuse of services;
- Ensure appropriate care for members with complex health needs;
- Ensure that the cultural and linguistic needs of Alliance members are met; and
- Ensure appropriate care for members with behavioral health needs.

The QPIP goals are achieved by employing the following:

- Maintaining accountability of care systems;
- Maintaining continuous quality monitoring utilizing specific quality and performance improvement methods; and
- Analyzing data, incorporating provider feedback and developing interventions.

The Continuous Quality Improvement Committee (CQIC) is the contractually-required quality improvement committee with oversight and performance responsibility of the QPIP – excluding credentialing/recredentialing activities, which are directed by the PRCC. Annually, the CQIC reviews and approves QPIP and Utilization Management Program policies (401-1101- Quality and Performance Improvement Program and 404-1101- Utilization Management Program) and work plans [the Quality Improvement Work Plan (QIWP) and Utilization Management Work Plan (UMWP)]. Once approved, the CQIC
Section 14. Quality and Performance Improvement Program

monitors QIWP and UMWP activities quarterly, ensuring implementation of interventions and re-measurement of performance goals and benchmarks.

For more information about the QPIP, please see Policy 401-1101- Quality and Performance Improvement Program.

**Member Satisfaction Surveys**

**Consumer Assessment of Healthcare Providers and Systems (CAHPS)**

Consumer Assessment of Healthcare Providers and Systems (CAHPS) was developed by the Agency for Healthcare Research and Quality (AHRQ) to advance understanding of patient experience with healthcare. The Department of Health Care Services (DHCS) conducts the CAHPS survey every three years, but the Alliance contracts with a vendor to conduct the survey every year to have an understanding of our member’s satisfaction with healthcare.

CAHPS is considered the national standard for measuring member’s experience related to the healthplan and its services. This also includes member’s experience with interacting with providers and staff, as well as health care facilities.

The survey is administered in the first quarter of the year and measures child and adult experiences. The child surveys are completed by the parent/guardian on behalf of the child. The survey includes the following measures:

- Rating of the Healthplan
- Getting Needed Care
- Customer Service
- Providing Needed Information
- Ease of Filling out Forms
- How Well Doctors Communicate
- Shared Decision Making
- Health Promotion and Education
- Coordination of Care
- Rating of Personal Doctor
- Rating of Specialist

For additional information on CAHPS please visit the AHRQ website at [https://www.ahrq.gov/cahps/about-cahps/index.html](https://www.ahrq.gov/cahps/about-cahps/index.html). Please refer to the Alliance’s Member Satisfaction Tool Kit for additional resource information.

**CAHPS Clinician & Group Survey (CG-CAHPS)**

The CAHPS Clinician & Group Survey assesses member’s experiences with their healthcare providers and staff in the doctors’ office. This survey is administered in the fourth quarter of the year to children and adult members, and measures the first six months of the year. Tax IDs with claims from more than 333 unique households will receive the survey.
The child surveys are completed by the parent/guardian on behalf of the child. The results of the survey are broken down by provider (doctor, nurse practitioner, physician assistant, or other provider). The survey includes the following measures:

- Getting Timely Appointments, Care, and Information
- How Well Providers Communicate With Patients
- Providers' Use of Information to Coordinate Patient Care (New to the 3.0 version)
- Helpful, Courteous, and Respectful Office Staff
- Patients' Rating of the Provider

For additional information on the CG-CAHPS please visit the AHRQ website at https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html. If you are interested in receiving your clinic results please email QI@CCAH-Alliance.org or contact your Provider Relations Representative at (800) 700-3874 ext. 5504. Please refer to the Alliance’s Member Satisfaction Tool Kit for additional resource information.

**Healthcare Effectiveness Data and Information Set (HEDIS®)**

The Alliance is contractually required by the California State Department of Healthcare Services (DHCS) to perform a quality measure audit that complies with DHCS’ Managed Care Accountability Set (MCAS). The MCAS aligns with Centers for Medicare and Medicaid Services’ (CMS) Child and Adult Core Sets, as well as with the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) quality measures. The audit assess how well the Alliance network is providing services to our members, while ensuring accurate and reliable measurement.

The Alliance’s Quality Improvement department begins preparations for the upcoming season by reviewing current rates and areas possible target areas for improvement. For more information about HEDIS, please see Policy 401-1607 Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight.

**HEDIS 2020 MCAS Planning**

HEDIS has a two phase approach, the first including a review of administrative measures consisting of claims, pharmacy, immunization registry, and supplemental data.

The second phase consists of administrative measures which are subject to medical record review. If these measures are not identified as compliant through administrative data, the Alliance may request specific medical records to establish additional measure compliance.

The 2020 MCAS includes a total of 35 measures. The Alliance is held to the Minimum Performance Level (MPL) for 19 of these measures. DHCS has shifted the MPL from the 25th to the 50th percentile for HEDIS 2020. Should the Alliance fall beneath the 50th percentile in any measures, it will be subject to economic sanctions and corrective action plans.
Please see the comprehensive list of 2020 HEDIS measures that the Alliance is held to MPL:

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>2020 (MY 2019) Measures Held to MPL</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR</td>
<td>Plan All-Cause Readmission</td>
<td>Claims</td>
</tr>
<tr>
<td>AWC</td>
<td>Adolescent Well-Care Visits</td>
<td>Claims, Medical Record Review</td>
</tr>
<tr>
<td>ABA</td>
<td>Adult Body Mass Index (BMI) Assessment</td>
<td>Claims, Provider Submitted Data</td>
</tr>
<tr>
<td>AMM-Acute</td>
<td>Antidepressant Medication Management - Acute Phase Treatment</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>AMM-Cont</td>
<td>Antidepressant medication Management - Continuation Phase Treatment</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>BCS</td>
<td>Breast Cancer Screening</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>AMR</td>
<td>Asthma Medication Ratio</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>CCS</td>
<td>Cervical Cancer Screening</td>
<td>Claims, Lab Data and Provider Submitted Data, Medical Records</td>
</tr>
<tr>
<td>CIS</td>
<td>Childhood Immunization Status (Combo 10)</td>
<td>Immunization Registry, Claims, Provider Submitted Data, and Medical Records</td>
</tr>
<tr>
<td>CHL</td>
<td>Chlamydia Screening in Women</td>
<td>Claims</td>
</tr>
<tr>
<td>CDC-HT</td>
<td>Comprehensive Diabetes Care: HbA1c Test</td>
<td>Claims, Lab and Pharmacy Data, Provider Submitted Data, and Medical Records</td>
</tr>
<tr>
<td>CDC-H9</td>
<td>Comprehensive Diabetes Care: HbA1c Poor Control (&gt;9.0%)</td>
<td>Claims, Lab and Pharmacy Data, Provider Submitted Data, and Medical Records</td>
</tr>
<tr>
<td>CBP</td>
<td>Controlling High Blood Pressure</td>
<td>Claims and Medical Records and Provider Submitted Data</td>
</tr>
<tr>
<td>PPC-Pre</td>
<td>Timeliness of Prenatal Care</td>
<td>Claims and Medical Records</td>
</tr>
<tr>
<td>PPC-Post</td>
<td>Postpartum Care</td>
<td>Claims and Medical Records</td>
</tr>
<tr>
<td>WCC</td>
<td>Weight Assessment: Body Mass Index (BMI)</td>
<td>Claims, Provider Submitted Data and Medical Records</td>
</tr>
<tr>
<td>IMA-2</td>
<td>Immunizations for Adolescents</td>
<td>Immunization Registry, Claims, Provider Submitted Data, and Medical Records</td>
</tr>
<tr>
<td>W34</td>
<td>Well-Child Visits in the 3 to 6 Years of Life</td>
<td>Claims and Medical Records</td>
</tr>
</tbody>
</table>
The Alliance is required to report the following measures to DHCS in 2020. These measures are currently not held to the MPL, but are expected to in 2021.

<table>
<thead>
<tr>
<th>ABBREVIATION</th>
<th>2020 MEASURES NOT HELD TO MPL</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMB-ED</td>
<td>Ambulatory Care: Emergency Department (ED) Visits</td>
<td>Claims</td>
</tr>
<tr>
<td>ADD-Init</td>
<td>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Initiation Phase</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>ADD-C&amp;M</td>
<td>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>CAP</td>
<td>Children and Adolescents’ Access to Primary Care Practitioners: 12 months to 19 years of age</td>
<td>Claims</td>
</tr>
<tr>
<td>CCW-MMEC</td>
<td>Contraceptive Care – All Women: Most or Moderately Effective Contraception</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>CCW-LARC</td>
<td>Contraceptive Care – All Women: Long Acting Reversible Contraception (LARC)</td>
<td>Claims and Pharmacy Data</td>
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<tr>
<td>CCP-MMEC3</td>
<td>Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>CCP-MMEC60</td>
<td>Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>CCW-LARC3</td>
<td>Contraceptive Care – Postpartum Women: LARC - 3 Days</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>CCP-LARC60</td>
<td>Contraceptive Care – Postpartum Women: LARC - 60 Days</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>DEV</td>
<td>Developmental Screening in the First Three Years of Life</td>
<td>Claims and Provider Submitted Data</td>
</tr>
<tr>
<td>HVL</td>
<td>Human Immunodeficiency Virus (HIV) Viral Load Suppression</td>
<td>Claims</td>
</tr>
<tr>
<td>MPM-ACE/ARB</td>
<td>Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)</td>
<td>Claims, Supplemental Data and Provider Submitted Data</td>
</tr>
<tr>
<td>MPM-Diu</td>
<td>Annual Monitoring for Patients on Persistent Medications: Diuretics</td>
<td>Claims, Supplemental Data and Provider Submitted Data</td>
</tr>
<tr>
<td>COB</td>
<td>Concurrent Use of Opioids and Benzodiazepines</td>
<td>Claims and Pharmacy Data</td>
</tr>
<tr>
<td>OHD</td>
<td>Use of Opioids at High Dosage in Persons Without Cancer</td>
<td>Claims and Pharmacy Data</td>
</tr>
</tbody>
</table>
CDF | Screening for Depression and Follow-Up Plan | Claims and Pharmacy Data

Please visit the HEDIS Website of the Alliance provider website for additional information on 2020 HEDIS measures and the appropriate billing codes for the measures listed above.

**Provider’s Role**

The role of the provider is very important in promotion of the health of Alliance members. The Alliance encourages providers to assist in facilitating the HEDIS process by:

- Providing appropriate care within the designated time frames defined by HEDIS
- Clearly documenting all care provided in the patient’s medical record
- Accurately coding all claims (see 2020 HEDIS Code Set on the HEDIS Website)
- Responding promptly and accurately to medical records requests (within five to seven business days of request)
- Providing the Alliance and its HEDIS vendor access to your electronic health record (EHR) system to reduce the impact on your medical records team, as well more accurately report your clinic’s performance.

**HIPAA Statement**

All providers are contractually obligated to provide the Alliance with medical records upon request. A patient release form is not necessary. HEDIS data collection and release of information is permitted under HIPAA since the disclosure of records is part of quality assessment and improvement activities. Please be assured that with providing the QI team and the Alliance’s HEDIS vendor EHR access Alliance members’ personal health information is maintained in accordance of federal and state laws.

**Continuous Quality Monitoring**

The QPIP uses a variety of mechanisms to identify potential quality of service issues, ensure patient safety, and ensure compliance with standards of care across the care continuum (i.e. preventative health services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services). These mechanisms include, but are not limited to:

- External quality review using the MCAS and NCQA’s HEDIS® measure calculation to evaluate the quality of care provided to our members and for comparison against national or regional benchmarks.
- Site reviews of PCP facilities for criteria such as: patient safety, physical accessibility, infection control and quality of medical records.
- Disease surveillance and reporting public health authorities, as applicable.
- Provider contracting, credentialing and recredentialing processes, including peer review activities.
• Timely access monitoring to ensure the provision of covered services in a timely manner.

• Member satisfaction monitoring including analysis of member satisfaction surveys, complaints and appeals.

• Provider satisfaction surveys.

• Medical and pharmaceutical claim/encounter data analysis to identify sentinel events, variations in practice and potential fraud, waste and/or abuse.

• Potential quality issue investigation and resolution processes, to ensure that services provided to members meet established standards, and address any patient safety concerns.

• Monitoring of over/under utilization of services to ensure appropriate, high quality, cost-effective utilization of health care resources and that these resources are available to all members.

• Group needs assessment to evaluate the health education and cultural and linguistic needs of members.

•Seniors and persons with disabilities activity studies to ensure coordination and continuity of care, availability and access to care, and the provision of case management services.

• Stratified data studies to evaluate population(s) as needed.

• Development and annual review of the QIWP and UMWP.

• Routine and ad-hoc monitoring of QI activities, behavioral health services and delegate oversight.

Communicating Results of QI Activities

Using a variety of communication methods (e.g., Provider Portal, newsletters, special mailings, educational sessions, and/or site reviews), QPIP activities are communicated to Alliance staff, the Alliance Board, oversight and advisory committees, regulatory agencies, providers, and members. The content of these communications may include:

• Listings of members who need specific services;

• Listings of members who need intervention based on pharmacy indicators;

• Comparison of practitioner/provider performance to average plan-wide performance;

• Reports showing practitioner/provider deviation from a benchmark or threshold;

• Recommended interventions to improve performance;

• Barrier analyses and intervention plans/timelines;

• Plan-sponsored training directed at improving performance;

• Incentives for improved or above average performance in quality of care or service;

• Requests for Corrective Action Plans to correct deficiencies
For more information about our QPIP, please see the following policies.

401-1101 - Quality and Performance Improvement Program
401-1201 - Continuous Quality Improvement Committee
401-1301 - Potential Quality Issue Review Process
401-1508 - Facility Site Review Process
401-1510 - Medical Record Review and Requirements
401-1509 - Timely Access to Care
401-1515 - Nurse Midwife Guidelines
401-1523 - Non-Physician Medical Practitioner Guidelines
401-1306 - Corrective Action Plan for Quality Issues
Section 15
Cultural & Linguistic Services Program

The Alliance is committed to delivering culturally and linguistically appropriate health care services to its diverse membership. The goal of the Cultural & Linguistic Services Program (CLSP) is to ensure that all Alliance members—regardless of race, color, religion, national origin, creed, ancestry, ethnic backgrounds, language, marital status, English proficiency, age, health status, physical and mental disability, gender, sexual orientation or gender identity or identification with any other persons or groups—all have equal access to quality healthcare and that covered services are provided in a culturally and linguistically appropriate manner. The CLSP encompasses language assistance services for members; and cultural competency, sensitivity, and diversity training of staff, providers, and subcontractors. Please see Policy 405-3101 - Cultural and Linguistic Services Program for more information.

Providers shall recognize and integrate members’ practices and beliefs about disease causation and prevention into the provision of Covered Services; comply with Plan’s Language Assistance Program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04; and cooperate with the Alliance by providing any information necessary to assess compliance.

Language Assistance Program / Interpreter Services

Under federal and state law, all Limited English Proficient (LEP) health plan members are entitled to free language assistance when accessing health care services. In addition, the Americans with Disabilities Act (ADA) requires that persons who are deaf or hard of hearing be offered free communication assistance when accessing healthcare services. The Alliance covers interpreter services for all LEP, deaf or hard of hearing members. The Alliance contracts with pre-approved and qualified agencies to provide these services. Providers and members are strongly encouraged to take advantage of the Alliance’s free interpreter services, as the Alliance does not reimburse for services that are not offered by the Alliance.

Telephonic Interpreter Services

- Telephonic interpreter services for LEP members can be accessed by providers for all Alliance-covered services through approved vendors. No prior approval is required.
- Providers may access a telephonic interpreter directly 24 hours a day, 7 days a week.

Face-to-Face Interpreter Services

- Face-to-face interpretation is approved for all covered services for deaf or hard of hearing members, and approved for LEP members only under special circumstances.
- Prior approval and scheduling is required for all face-to-face interpreting services. Providers can request prior approval and schedule these services by submitting the Interpreter Request Form on the Cultural and Linguistic Services page of the Alliance provider website.
- A minimum of 7 business days for all standard (non-urgent) American Sign Language (ASL) requests.
- A minimum of 10 business days for all standard Non-ASL requests (e.g. foreign language).
Section 15. Cultural & Linguistic Services Program

- Urgent requests can be submitted at any time, and will be reviewed immediately upon receipt. A determination will be made within one (1) business day.

For instructions on how to access telephonic and face-to-face interpreter services, including the approved vendors, please download the Interpreter Services Quick Reference Guide. Please see Policy 405-3103 - Interpreter Services for more information.

Summary of Providers Responsibilities and Requirements

- Due to the complex and sensitive nature of medical care, it is not appropriate to use unqualified bilingual persons as interpreters.

- The Alliance strongly discourages the use of unqualified interpreters, including bilingual office staff or patients’ friends or family members, especially minors.

- Providers are required to document every patient’s preferred language in the medical record and to offer LEP and deaf or hard of hearing patients a qualified interpreter at no cost to the patient.

- Providers must not require patients to bring their own interpreters or suggest that they use a friend or family member to interpret.

- Providers are required to document the offer of and patient acceptance or refusal of interpreter services in the medical record.

- Federal and state laws require medical providers to offer qualified interpreters when needed. Using an untrained interpreter may result in miscommunication of medical information and compromise quality of care.

For a brief summary of federal and state laws related to language assistance, the use of interpreters, and cultural competence, please visit the Cultural and Linguistic Services page of the Alliance provider website.
Section 16
Pharmacy Services

The Alliance has subcontracted with MedImpact to provide pharmacy services to all members. Members must go to a MedImpact-participating pharmacy for prescriptions. For more information regarding the Alliance Pharmaceutical Services Access, please see Policy 403-1126 – Pharmaceutical Services Access.

Drug Formulary

The Alliance has its own drug formulary, developed with input from local providers. Our formulary, which is not the same as the state formulary, is reviewed and updated annually. Please refer to the Alliance Formulary to find out if a particular medication is listed. You may download a copy of the formulary directly from the pharmacy page on the Alliance provider website or from www.epocrates.com.

Carved-Out Drugs

The Alliance formulary contains drugs from all therapeutic classes except for those that are carved out of the Alliance pharmacy benefit. The Alliance does not cover drugs in the following classes: antipsychotics, AIDS drugs, Blood Factors, Coagulation factors, Alcohol detoxification drugs, Heroin Detoxification drugs, and Dependency Treatment drugs (Buprenorphine, etc.). These carved-out drugs should be billed to state Fee-for-Service Medi-Cal.

Authorizations for Non-Formulary Drugs

Prior authorization is necessary for a prescription drug that is not on the Alliance Drug Formulary or exceeds the limit of days, age, quantity, or cost allowed per formulary. Beginning January 1, 2015, prior authorization requests must be submitted on the Prescription Drug Prior Authorization Request Form for Alliance Care IHSS members. This form can be found on the pharmacy page on the Alliance provider website or Form Library. Submissions on other forms will not be accepted. Use of this form for Medi-Cal members is encouraged, but optional, at this time.

Submission of prior authorization requests is preferred through the Alliance Provider Portal. Alternatively, providers may submit requests by fax to (831) 430-5851 or by mail to:

Central California Alliance for Health
Health Services Department – Pharmacy
PO Box 660012
Scotts Valley, CA 95067-0012

Questions regarding urgent prior authorization requests may be directed to the Alliance Pharmacy department by calling (831) 430-5507 or (800) 700-3874 ext. 5507.
To complete a prior authorization request, all of the following information must be provided:

- Member name, ID number and DOB.
- Requesting provider name and contact information.
- Description of requested drug or item (must include Healthcare Common Procedure Coding System (HCPCS) code if physician or facility administered drug is requested).
- All of the following are also required for an authorization request to be considered complete:
  - Prescriber name, address, phone number and fax number.
  - Pharmacy name, address, phone number and fax number (if authorization submitted by pharmacy).
  - Diagnosis (or ICD code) that most accurately describes the indication for the medication. Please include all medically relevant diagnoses for review purposes.
  - Quantity requested per fill or per date of service (DOS).
  - Number of fills or DOS requested.
  - Directions for use.
  - Expected duration of therapy.
  - Documentation of appropriate clinical information that supports the medical necessity of the requested drug or item, including:
    - Other drugs or therapies for this indication that have already been tried and failed. Please include what the outcomes were.
    - Why alternatives on the Alliance formulary cannot be used.
    - Any additional information to support diagnosis and medical justification such as lab results and specialist consults.

Incomplete and/or illegible forms may be denied or voided.

Approval of a non-formulary drug will be given if the patient has failed treatment with formulary alternatives or has intolerable side effects or contraindications to formulary alternatives. Trials conducted through the use of samples will be redirected to formulary equivalent medications.

The Alliance will prefer the use of a biosimilar if the member has not tried its branded counterpart. If a member is stable on a biosimilar’s branded counterpart, the Alliance will allow the member to continue utilizing the non-biosimilar. For more information, please see Policy 403-1142 - Biosimilars.

For providers who wish to administer Synagis in their office, the Statement of Medical Necessity form is required to be submitted along with the prior authorization request. The Alliance will cover Synagis for members who meet Conditions of Usage listed in Policy 403-1120 – Synagis.

Providers can contact the Alliance Pharmacy department at (800) 700-3874 ext. 5507.
For more information on the authorization review process, please see Policy 403-1103 - Pharmacy Authorization Request Review Process.

**Authorizations for Physician-Administered Drugs**

Physician-administered drugs that require prior authorization will have criteria consistent with pharmacy benefit criteria based on the recommendations of the Pharmacy and Therapeutics Committee. Prior authorization for the pharmacy benefit will be applicable to pharmaceutical physician administered drugs. If a physician/facility administered drug requiring prior authorization has no prior authorization criteria, it will be reviewed for medical necessity.

For more information on the authorization review process for physician/facility administered drugs, please see Policy 403-1141 – Physician/Facility-Administered Drugs Requiring Prior Authorization.

**Alliance Opioid Policies**

The Alliance has developed policies in collaboration with internal and external stakeholders to help ensure the safe and appropriate use of opioid medications.

**Opioid Quantity Limits**

Quantity limits have been established for formulary opioid medications. Requests for quantities greater than the quantity limits per policy will require a TAR submission and will be reviewed for medical necessity. For more information on Opioid Quantity Limits, please see Policy 403-1121 - Quantity Limits for Opioid Medications.

**Opioid Utilization Review**

The Alliance has established 50 mg MED (morphine equivalent dose) as the opioid ceiling for the treatment of chronic non-cancer pain. For members stable on high-dose regimens, providers will have to submit chart notes, a CURES attestation, and medical justification for plans for tapering (or why the member cannot be safely tapered) for continuation of care. For more information on the Opioid Utilization Review process, please see Policy 403-1139 - Opioid Utilization Review.

**Opioid Refill Policy**

The Alliance will allow refills for opioid prescriptions when greater-than or equal-to 90% of the days' supply of the prescription is met. The next refill request, for when less than 90% of the days' supply of an opioid prescription has elapsed, will require a prior authorization with medical justification for early refill. For more information on the opioid refill process, please see Policy 403-1140 - Opioid Refill Policy.

**After Hours Access**

24-hour access is provided by any 24-hour pharmacy that contracts with the Alliance’s PBM. Currently, access to 24-hour pharmacies is available in Santa Cruz (Watsonville) and Monterey (Salinas and Seaside) counties.

When there is an emergency after the Alliance’s business hours (Monday-Friday 8:00 – 5:00 PM PST) or on holidays, the Alliance’s PBM is authorized to enter a five-day override if the pharmacy states that it is for an
emergency. The Alliance will receive and retroactively review a report of all emergency overrides placed by
the PBM. MedImpact is the Alliance’s PBM and they can be reached at (800) 788-2949.
Alternatively, pharmacies can dispense a 72-hour supply of medically necessary non-formulary medication(s)
if the pharmacist deems it is an emergency and the Alliance is closed. A retroactive prior authorization
request can be submitted by the pharmacy for the 72 hour supply and will be approved by the Alliance on
the next business day.

**Continuity of Care for New Members**

In the event that a new member is being treated with a non-formulary drug at the time of their enrollment
with the plan, the Alliance will work with Alliance providers to ensure that they receive continuity of care with
their pharmaceutical services.

For more information on continuity of care for new members, please see Policy 403-1114 - Continuing
Pharmacy Care for New Members.

**Drug Utilization Review (DUR)**

The Alliance operates a DUR program to educate physicians and pharmacists to better identify patterns, and
reduce the frequency of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care, both
among physicians, pharmacists, and patients, and fraud or abuse associated with specific drugs or groups of
drugs. For more information on the DUR program, please see Policy 403-1143 - Drug Utilization Review.

**Billing and Reimbursement**

**Billing for “Carved Out” Medications**

Procedures for Fee-for-Service reimbursement for "carved out" medications for psychiatric illnesses,
substance abuse treatment, HIV/AIDS, erectile dysfunction and coagulation factors can be found on the
Medi-Cal website in the Part 2 manual for Pharmacy. The complete list of “carved out” medications can be
found on pages 6-8 of the MCP: County Organized Health System file.

For information on how to obtain reimbursement for compounding drugs, please see Policy 403-1135 -
Compound Drugs Requiring Special Handling.

The Alliance 340B Pharmacy Program

For information on billing for drugs purchased under the 340B program, please see Policy - 403-1145-
Pharmacy 340B Program.

For information on billing for drug waste, please see Policy – 403-1146-Drug Waste Reimbursement

**Additional Pharmacy Benefits**

**Enteral Nutrition Product Benefit**

Prior authorization is required for all Enteral Nutrition Products, including nutrition support (tube feed)
formulas, oral nutrition supplements and specialty infant formulas. Prior authorization requests can be
submitted by the prescribing or servicing provider, and may be submitted via the Provider Portal or fax. A
copy of the prescription and recent chart notes detailing the member’s diagnosis and medical necessity of the product being prescribed must be submitted. The criteria the Alliance uses to review authorization requests for medical necessity is outlined in the *Enteral Nutrition Products* section of the Medi-Cal Part 2 Pharmacy Provider Manual and further defined in Appendix A of Policy 403-1136 – Enteral Nutrition Products.

**Medical Nutrition Therapy**

Medical Nutrition Therapy (MNT) provided by a provider (MD, DO, PA, NP or an RD is a covered Benefit for all lines of business for members that meet qualifying conditions or deemed at nutritional risk. Treatment authorization request must be submitted for authorization.

Providers offering MNT to Alliance members should use the following codes for authorization and claims payment:

- **CPT-4 Code 97802** - MNT, initial assessment and intervention, individual, face-to-face with patient, each 15 minutes.
- **CPT-4 Code 97803** - MNT, re-assessment and intervention, individual, face-to-face with patient, each 15 minutes.
- **CPT – 4 Code 97804** - MNT, group (2 or more individual (s)), each 30 minutes.

Annual MNT coverage is a maximum of 3 hours for the first calendar year and 2 hours per calendar year in subsequent years.

Conditions include but are not limited to;
- HIV/AIDS
- Cancer with significant weight loss
- End Stage Renal Disease
- Conditions impairing digestion and absorption
- Underweight status or unintended weight loss

For more information on MNT, please see Policy 403-1149 - Medical Nutrition Therapy.

**OTC Acetaminophen and Sharps Containers**

Since 2011, over the counter (OTC) acetaminophen products have not been a covered benefit for state Medi-Cal. However, the Alliance continues to cover OTC acetaminophen products *with a prescription* for our Medi-Cal members. The Alliance also provides coverage of sharps containers for all members who receive diabetic supplies or self-injectable prescription drugs. A *prescription is required* for Medi-Cal Members to obtain OTC acetaminophen and sharps containers.
Alliance members and both contracted and non-contracted providers may access the Alliance Grievance Process at any time. To download the necessary forms, go to the Form Library.

**Provider Inquiries and Disputes**

The Alliance has a two-level process to resolve Provider disputes. Provider Inquiries investigate and resolve contested claims and/or payment issues. A Dispute may be submitted to contest the processing, payment or non-payment of a previously submitted Provider Inquiry. Providers must complete the Provider Inquiry process prior to submitting a Dispute.

The Alliance scans and reviews all inquiries, disputes and written statements of contested claims or provider dissatisfaction to determine if the request meets criteria for processing as a Provider Inquiry (level 1) or a Dispute (level 2). The Alliance will process written statements and requests according to the criteria stated in the definitions for these processes. Example: If the provider states on their PIF that they are disputing a claim denial, but the contested claim has not yet been reviewed through the level 1 Provider Inquiry process, the Alliance will first process the contested claim as a Provider Inquiry, allowing the provider to further submit a level 2 Dispute if still dissatisfied with the Inquiry decision.

Inquiries and disputes must be filed with the Alliance within 365 days of the action or decision being disputed or, in a case where the dispute addresses the Alliance’s inaction, within 365 days of the expiration of the Alliance’s time to act. Contracted providers must exhaust this dispute resolution process before pursuing other available legal remedies.

Prior to filing an inquiry or dispute, providers should contact the Alliance Claims department to identify whether or not their claim denial issue can be addressed immediately over the phone. Please contact a Claims Customer Service Representative at (831) 430-5503, Monday-Friday, 9AM-4PM.

For more information, please see Policy 600-1017 Provider Inquiry and Dispute Resolution.

**Inquiry and Dispute Resolution Process**

Provider Inquiries and Disputes must be submitted in writing. You may mail, fax or deliver your hard copy dispute to:

**Central California Alliance for Health**  
ATTN: Provider Inquiries and Disputes  
1600 Green Hills Road, Suite 101  
Scotts Valley, CA 95066

Fax: (831) 430-5569

You may also submit a Provider Inquiry or Dispute electronically using the form located on the Alliance website. Inquiries and disputes may be emailed to CQID@ccah-alliance.org.
Section 17. Resolution of Disputes and Grievances

Inquiries and disputes must include the following information:

- Provider name.
- Provider NPI, Tax ID, or Alliance ID number.
- Provider contact information.
- A clear explanation of the issue in question.
- Your position on the matter.
- If the inquiry or dispute involves a claim or request for reimbursement of overpayment, you also must include:
  - The contested claim number, and all other claim control numbers if there have been multiple resubmissions of the claim.
  - A clear identification and description of the contested item.
  - The date of service.
  - A clear explanation of why you believe the payment or other action is incorrect.
- If the inquiry or dispute involves a member, you must include the member’s full name and Alliance ID number.

You also may include additional supporting clinical information, if applicable. Please note that, if the inquiry or dispute does not include the above information and we cannot readily obtain it, we will return the request to you for more information. Providers have thirty (30) working days to submit an amended dispute to the Alliance.

If you have multiple inquiries or disputes addressing a single issue you may file a single request using the system described above. Please include a list of each individual issue, along with the original CCN(s) and all other information required for filing multiple disputes.

The Alliance will acknowledge inquiries and disputes within ten (10) business days of receipt for hard copy cases, or within two (2) business days of receipt for requests received electronically.

The Alliance will send a written resolution to inquiries and disputes within thirty (30) business days of the date we receive the request for contracted providers and forty-five (45) business days for non-contracted providers.

For assistance in filing a dispute, or to receive the status update of a dispute, please contact a Dispute Coordinator at (831) 430-4105.

FAQs about Provider Disputes

What next steps should I take if a pre-service or prior authorization denies for lack of information?

Resubmit the authorization request to Health Services with the requested information directly to their Fax number at (831) 430-5850.
What if I disagree with the claims denial for all cases except an unclean claim?

The provider should submit a provider inquiry request to contest the denial within three hundred sixty five (365) days from the original Remittance Advice (RA) date. Ensure to include all required information listed above such as the original Claims Control Number (CCN), provider information, and a short explanation explaining the provider’s position.

What if I noticed a mistake and adjusted the claim? May I still file a dispute?

Please submit a clean claim within the allowable timeframe as a corrected claim or resubmission directly to the Claims department for a complete review. New information should be reviewed by Claims prior to initiating a dispute.

May I balance bill a member when a claim is disputed?

Central California Alliance for Health prohibits Providers from balance billing a member for contested claim denials. The Provider is expected to adjust the balance owed. For more detailed information regarding balance billing, please see section 10 Claims in this manual.

Member Grievances and Appeals

The Alliance Grievance Process addresses member grievances, also referred to as complaints, and appeals. An Alliance member may file a complaint about their experiences with the Plan or with a contracted provider. If a member is filing an appeal about a denial, modification or deferral of service by the Alliance, it must be filed within 60 days of the Notice of Action. While most providers have their own internal mechanisms for resolving patient complaints, we provide complaint forms in English, Spanish and Hmong.

Provider Responsibilities

When a member brings a complaint to your attention, you must investigate and try to resolve the complaint in a fair and equitable manner. In addition, providers must cooperate with the Alliance in identifying, processing and resolving all member complaints and appeals. Cooperation includes: speaking or meeting with representatives of the plan if asked to do so, providing us with information pertinent to the complaint or appeal, including supplying medical records, and taking all reasonable actions suggested by our staff to resolve member’s complaint. Member complaints are also considered by the Peer Review and Credentialing Committee (PRCC) in re-credentialing of providers.

If a member asks to file a complaint, you may click the link(s) below to access the appropriate forms and instructions. *Please note that the Member Complaint and Appeal Form must be signed by the member or the Member’s Authorized Representative in Step 3.

- English Member Grievance Packet
- Spanish Member Grievance Packet
- Hmong Member Grievance Packet

Members have the right to express their dissatisfaction with any aspect of the plan or its providers. Providers can refer members to the following resources to file a complaint or appeal. A complaint or appeal may be filed by a member or a member’s authorized representative:
Section 17. Resolution of Disputes and Grievances

- In person, by making an appointment to meet with a Member Services Representative at one of our offices:
  
  **Santa Cruz County:**
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066-4981

  **Monterey County:**
  950 East Blanco Road, Suite 101
  Salinas, CA 93901-3400

  **Merced County:**
  530 West 16th Street, Suite B
  Merced, CA 95340-4710

- By calling a Member Services Representative at:
  
  **Santa Cruz County:** (831) 430-5500
  **Monterey County:** (831) 755-6000
  **Merced County:** (209) 381-5300

  The TTY line for the hearing and/or speech impaired: (877) 548-0857.

- By fax to (831) 430-5579.

- By calling the Grievance Coordinator at (800) 700-3874, ext. 5816.

- By filling out a complaint form or putting the complaint in writing and sending it to the Grievance Coordinator at:
  
  Central California Alliance for Health
  ATTN: Grievance Coordinator
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066-4981

- Electronically, by visiting the File a Complaint page on the Alliance website.

When we receive a complaint or appeal, we will send the member a written acknowledgement letter within five (5) calendar days. The letter will reiterate the issue(s) of concern as we understand it. We will also identify the Grievance Coordinator as the contact person for the complaint, notify the member of their rights in the Grievance Process, and tell the member they will receive a proposed resolution letter within thirty (30) calendar days from the date the complaint or appeal was received.

In some cases, members do not need to use the Alliance Grievance System to resolve their complaint or appeal. Refer to the member Grievance packets linked above, or the Alliance website for information about other options Medi-Cal and IHSS members have to resolve their grievances.

**Member Rights in the Alliance Grievance Process**

A member may authorize a friend or family member to act on their behalf in the grievance process. If the member does not speak English fluently, they have the right to interpreter services.
A member has the right to obtain representation by an advocate or legal counsel to assist them in resolving the grievance.

The State Office of the Ombudsman will help Medi-Cal members who are having problems with the Alliance. Members may call (888)-452-8609.

Medi-Cal members have the right to file a request for a State Fair Hearing (SFH) with the Department of Social Services if they have gone through the Alliance appeal process and received a notice of appeal resolution letter, or if the Alliance failed to adhere to appeal timeframes. Members must request a SFH within one hundred and twenty (120) days of receiving their appeal resolution letter.

Members have the right to request continuation of benefits during an appeal or SFH. Alliance Care IHSS members have the right to request a review by the California Department of Managed Health Care if they are unhappy with the Alliance’s resolution of their complaints or if a complaint remains unresolved after 30 days.

Alliance Care IHSS members have the right to request an Independent Medical Review (IMR) if their complaint involves a denial or partial denial of a health care service that was determined not to be medically necessary.

FAQs for Members on Grievances and Appeals

What is the Alliance Member Grievance System?
This is the system for resolving member complaints and appeals about the services a member receives as an Alliance member. Filing a complaint or appeal will not affect a member’s health care coverage through the Alliance. Filing a complaint or appeal is the member’s choice and their cooperation in the process is voluntary.

Why would a member file a grievance or complaint?
A member could file a complaint if they:

- Encounter delays receiving health care services that the member thinks they need; such as medications, medical equipment, or doctors appointments.
- Are not happy with the services they received from a health care provider.
- Are unhappy with any aspect of their health care.
- Feel a health care provider or the Alliance has not respected their privacy.

Why would a member file an appeal?
Another reason why a member might file a grievance is if they receive Notice of Action. A Notice of Action is a formal letter telling the member that a medical service has been denied, deferred, or modified. This type of complaint is also called an appeal. If a member receives a Notice of Action from the Alliance, the member has sixty (60) days from the date on the Notice of Action to file an appeal with the Alliance.

How do a member file a grievance/complaint or appeal?
A member can file a complaint or appeal in one of the following ways:
Call Member Services Representative at:
Section 17. Resolution of Disputes and Grievances

Scotts Valley: (831) 430-5505
Salinas: (831) 755-6000
Merced: (209) 381-5300
Toll Free: (800) 700-3874
TTY: (877) 548-0857

Call an Alliance Grievance Coordinator at (800) 700-3874 ext.5816.

Document your complaint and mail it to:
Grievance Coordinator
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066

Fill out a How To File a Complaint form on the Alliance website.

Call and make an appointment to come to any of our offices in person, Monday - Friday, 8:00 a.m. - 11:00 a.m. or 2:00 p.m. - 4:00 p.m. We have offices in Scotts Valley, Salinas and Merced:

Scotts Valley:
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
(831) 430-5500

Salinas:
950 East Blanco Road, Suite 101
Salinas, CA 93901-3400
(831) 755-6000

Merced:
530 West 16th Street, Suite B
Merced, CA 95340-4710
(209) 381-5300

What if the member prefer to speak a language other than English?
The Alliance has staff who speak Spanish and Hmong. We will also arrange an interpreter for the member through a telephone language line if the member does not speak English, Spanish, or Hmong.

Are there other ways to resolve a member’s problem if they are a Medi-Cal member?
If the member has filed an appeal with the Alliance and received an appeal resolution letter, or if the Alliance did not resolve or respond to the member’s appeal according to the timelines outlined above, the member can ask for a State Hearing. The member must request the hearing within 120 days from the date of receiving the Alliance’s appeal resolution letter.

The member may call the California Department of Social Services (DSS) at 1-800-952-5253 (TDD: 1-800-952-8349) to request a hearing or can fax their request to DSS at 1-916-651-5210.

You can also ask for a hearing at any of these local offices:

Santa Cruz County:
Human Resources Agency
1000 Emeline Street
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Santa Cruz, CA 95060
(831) 454-4117

**Monterey County:**
Department of Social Services
1000 South Main Street, Suite 208
Salinas, CA 93901
(831) 755-4477

**Merced County:**
Merced County Human Services Agency
Attn: Hearing Coordinator
2115 West Wardrobe Avenue
Merced, CA 95341
(209) 385-3000

Alliance members also have the right to file a complaint with the Department of Health and Human Services at any time if they feel that their privacy has not been respected. Members can file their complaint by contacting:

**Department of Health and Human Services**
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
**Section 17. Resolution of Disputes and Grievances**

**What if the member needs help to file my complaint or appeal?**

The member can authorize another person such as a family member or a friend to help you. The member can call the State Office of the Ombudsman at **1-888-452-8609** if the member has Medi-Cal. The member can call the California Office of the Patient Advocate at **1-866-HMO-8900** if the member has Alliance Care IHSS.

**What happens after a member files a complaint or appeal?**

The Grievance Coordinator will send the member a letter within 5 days after they file a complaint or appeal. This letter tells the member that we received the grievance. It explains the members rights in the grievance process.

**How is the complaint or appeal resolved?**

Depending on the type of complaint or appeal made, our staff may be able to resolve it very quickly. If this is not possible, we work with our own Alliance departments or providers to get it resolved.

If we need more information we will ask for it. For example, if the Chief Medical Officer wants more information, we may ask for medical records from the doctors involved. The Grievance Coordinator will send the resolution in a Proposed Resolution Letter.

**How long does the member have to wait until they get the Proposed Resolution Letter?**

The Grievance Coordinator will send the proposed resolution letter within 30 days from the day the complaint was received.

**What if the complaint or appeal involves a serious threat to my health?**

If the member's health problem is urgent, meaning it is a serious threat to their health, the member may ask for an Expedited Review. If the member requests an Expedited Review, the Grievance Coordinator will inform the member within twenty-four (24) hours that the complaint has been received. A resolution will be completed within 3 days or seventy-two (72) hours. An Expedited Review involves an imminent or serious threat to the member's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function.

**If you are an In-Home Supportive Service (IHSS) member:**

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-700-3874** or TDD **1-877-548-0857** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website [www.dmhc.ca.gov](http://www.dmhc.ca.gov) has complaint forms, IMR application forms and instructions online.
This section includes information on the Primary Care Provider (PCP), Specialist and Member incentive programs offered by the Alliance in 2020. These programs are evaluated by the Alliance on an annual basis to ensure they are achieving their intended outcomes which include improving access, coordination, quality and efficiency of care, and supporting members in making decisions that improve their health outcomes.

Specialist Incentive Program 2018-2019

Specialty Care Incentive Overview
The Specialty Care Incentive (SCI) program compensates participating referral providers for offering Alliance Medi-Cal members access to certain specialty medical services. It is designed to improve Alliance Medi-Cal member access to specialty care services and encourage specialty care physician participation in the Alliance Medi-Cal program.

The Alliance, at its sole discretion, may set aside a pool of money each year from which to pay SCI incentive (SCI Pool). Generally, the portion of the SCI Pool a provider will receive is determined by calculating the portion of the total qualifying referral services provided to Alliance Medi-Cal members, performed by the provider during the calendar year. Information for this incentive program is gathered through claims data.

To participate in SCI, a provider must have had its contract amended by the Alliance to add the SCI addendum. Payment under SCI is made to the entity with which the Alliance is contracted.

Calculation of SCI Payment
Providers are assigned points for providing qualifying referral visits to Alliance Medi-Cal Members. Initial visits are awarded two points, while additional visits are awarded one point.

Provider’s total SCI points are determined by adding all SCI points that the provider earned for initial and subsequent visits during the SCI Term (Provider’s Total SCI Points). The portion of the SCI Pool that the provider receives (Provider’s SCI Share) is calculated by dividing the Provider’s Total SCI Points by the sum of the SCI Points earned by all SCI eligible providers during the SCI Term (Total SCI Points of all Providers). The payment amount that the provider receives under the SCI program is calculated by multiplying Provider’s SCI Share by the SCI Pool. Calculation of Provider’s SCI Share and Provider’s SCI Payment are illustrated on the following page.
Section 18. Provider and Member Incentives

Calculation of Provider’s SCI Share

\[
\text{Provider’s Total SCI Points} \div \text{Total SCI Points of all Providers} = \text{Provider’s SCI Share}
\]

Calculation of Provider’s SCI Payment

\[
\text{Provider’s SCI Share} \times \text{SCI Pool} = \text{Provider’s SCI Payment}
\]

For additional information regarding the SCI program, including definitions, funding, accounting, and distribution of payment, providers participating in SCI should reference the Referral Physician Specialty Care Incentive Program addendum or exhibit added to their Referral Physician Services Agreement.

Primary Care Physician Incentives 2020

Care-Based Incentive Program Overview

The Alliance’s Care-Based Incentives (CBI) Program is designed in collaboration with our providers. The CBI Program consists of a set of measures to encourage preventive health services and connecting members with their primary care physicians (PCP). The program offers financial incentives, as well as technical assistance to PCPs to support providers in assisting members to self-manage their care and reduce proximal healthcare costs in the following areas:

- Care Coordination
- Quality of Care
- Performance Targets
- Exploratory (formerly provisionary)
- Practice Management

Although the CBI Program evaluates performance on the Alliance’s Medi-Cal line of business, the Alliance encourages quality, cost-efficient care for all your patients.

For a Provider to participate in the CBI program each year, the Provider and the Alliance must execute an amendment adding CBI to the Provider’s contract. The description of the CBI program included in this Provider Manual is intended to provide a general overview of the program. It does not modify or alter in any way the terms and conditions of the program for providers contracted to participate in the CBI Program.

For more information about the CBI Program, please see Policy 401-1705 – Care Based Incentive Program.

CBI Programmatic Incentives

Under the CBI Programmatic Incentives, Provider’s performance during the CBI term is measured against applicable benchmarks or performance targets and then compared to the performance of other CBI Providers to determine Provider’s CBI Programmatic Incentive Payment. The CBI Programmatic Incentive contains three categories of measures: (1) Care Coordination Measures, (2) Quality of Care Measures, and (3) Performance Target Measures. General information regarding CBI Programmatic Incentive measures is provided below. For more information on the CBI measures, including incentive payment amounts, visit our CBI Resources Website page on the Alliance website.
1. **Care Coordination (CC) Measures:** Care Coordination – Hospital & Outpatient Measures, a Provider’s performance is compared to the performance of providers within the same comparison group (i.e. Family Practice, Internal Medicine or Pediatrics). Under the Care Coordination – Access Measures, a Provider’s performance is based on their rate of achievement under each measure.

   **To qualify for the Care Coordination – Access Measures,** which include Initial Health Assessment (IHA), Alcohol Misuse Screening and Counseling (AMSC), Developmental Screening in the First Three Years, and Post-Discharge Care measures, providers must have a minimum of 5 eligible linked members at the end of the CBI Term.

   **To qualify for the Care Coordination – Hospital Measures,** which include Ambulatory Care Sensitive admissions (ACSA), Preventable Emergency Visits, and the 30-Day Readmissions measures, Providers must have 100 eligible linked members, on average, during the 2020 calendar year or 100 linked members as of December 31, 2020. Continuous enrollment requirements also apply to all care coordination measures. California Children’s Services (CCS) Members are excluded from Care Coordination measures.

   Visit the [CBI Resources page of the Alliance provider website](#) for a list of diagnoses included in the Ambulatory Care Sensitive admissions (ACSA) and the Preventable Emergency visits measures.

2. **Quality of Care (QoC) Measures:** The Quality of Care (QoC) Measures are calculated using the National Committee for Quality Assurance (NCQA) Medicaid benchmarks, following the Healthcare Effectiveness Data and Information Set (HEDIS) methodology. In order for a provider to receive points for a QoC Measure, they must have a minimum of 5 eligible linked members that qualify for the measure based on HEDIS specifications. The 13 QoC Measures for 2020 are shown below.

   - Antidepressant Medication Management
   - Asthma Medication Ratio
   - BMI Assessment: Adult
   - BMI Assessment: Child
   - Cervical Cancer Screening
   - Diabetic HbA1C Poor Control >9.0%
   - Immunizations: Adolescents
   - Immunizations: Children (Combo 10)
   - Maternity Care: Prenatal
   - Maternity Care: Postpartum
   - Well-Adolescent Visit 12 - 21 Years
   - Well-Child Visit 3 - 6 Years
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- Well-Child Visits First 15 Months of Life

**Performance Target Measure:** The Performance Improvement Measure allows providers to receive performance improvement points for every measure they qualify for by either:

- Meeting the plan goal (90th percentile or above), or
- Achieving a 5% improvement compared to the prior year.

3. **Exploratory Measures:** The Exploratory Measures (formerly Provisionary Measures) are a part of the CBI Program to monitor performance and are considerations for possible inclusion as a paid measure in the 2021 CBI Program. These measures do not qualify for payment in 2020. CCS Members are excluded from the 90-Day Referral Completion, Application of Dental Fluoride Varnish, and Breast Cancer Screening measures. The Exploratory Measures are shown below:

- 90-Day Referral Completion
- Application of Dental Fluoride Varnish
- Breast Cancer Screening
- Chlamydia Screening in Women
- Controlling High Blood Pressure
- Immunizations: Adults
- Member Satisfaction

**CBI Programmatic Measure Benchmarks**

The 2020 Programmatic Benchmarks indicate the rate of performance a provider site must achieve in order to receive points for a measure. Total CBI year end payments are dependent on the total number of points a provider site receives. The final programmatic payment amounts are calculated using: 1) total programmatic points received, total number of eligible member months, and 3) distribution percentages determined by comparison to the totals for CBI Providers of the same comparison group (pediatrics, internal medicine and primary care).

In the event a HEDIS benchmark is not published for a Quality of Care Measure, the Alliance will determine a rate of achievement.

For additional information on the CBI Benchmarks visit the CBI Resources page on the Alliance website.

**CBI Fee-For-Service Incentives**

**Fee-For-Service Measures Overview**

In contrast to CBI Programmatic Incentive, which is paid based on provider’s performance as compared to applicable benchmarks or performance targets, CBI Fee-for-Service (FFS) Incentives are single payment incentives to PCP sites and require providers to submit an attestation or certification of achievement to qualify for payment. The Alliance is offering three CBI FFS Incentives in 2020 for the measures shown below.
For more information on the CBI measures, including incentive payment amounts, visit our CBI Resources page on the Alliance Website.

- Behavioral Health Integration
- Buprenorphine License (X-License Waiver)
- Patient Centered Medical Home (PCMH) Recognition

**CBI Payments**

Provider Incentives are paid to qualifying contracted provider sites, including family practice, pediatrics and internal medicine. As noted above, provider incentives are broken into Programmatic and Fee-For-Service (FFS). Programmatic and FFS Measures vary in the frequency which they are paid and the incentive payment calculation methodology.

- Programmatic measures are paid annually based on their rate of performance in each measure.
- Fee-For-Service measures are paid quarterly

**CBI Resources**

The Alliance’s Provider Portal is a resource that offers monthly Quality Reports on claims data received for relevant measures to assist providers in monitoring their patients. The CBI Reports allow providers to view accumulative summaries of both Programmatic and Fee-for-Service measures by quarter.

Note: Claims data is subject to lag and is based upon the Provider’s submissions. The measurement of the CBI data is subject to variation, reasonable statistical and operational error.

The Alliance’s Data Submission Tool is available on the Provider Portal to allow providers to upload data for a selection of measures to achieve compliance in CBI. The Data Submission Tool Guide, available on the Provider Portal, provides step-by-step instructions, required information, and how to upload the data. If you do not have access to the Provider Portal Data Submission Tool or have additional questions, contact your Provider Relations Representative.

For additional CBI resource information please visit the Alliance’s CBI Resources Website, or contact your Provider Relations Representative.

**Value-Based Payment Program**

The Department of Health Care Services (DHCS) VBP Program is new for 2020. It will be administered through Medi-Cal Managed Care Health plans to provide incentive payments to qualifying providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. Implementation date is July 1, 2019 for all measures.

**Value-Based Payment Program Domains and Measures**

- Prenatal/Post-partum Care Domain
  - Prenatal Pertussis (‘Whopping Cough’) Vaccine
  - Prenatal Care Visit
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- Postpartum Care Visit
- Postpartum Birth Control

- Early Childhood Domain
  - Well Child Visits in First 15 Months of Life
  - Well Child Visits in 3rd-6th Years of Life
  - All Childhood Vaccines for Two Year Olds
  - Blood Lead Screening
  - Dental Fluoride Varnish

- Chronic Disease Management Domain
  - Controlling High Blood Pressure
  - Diabetes Care
  - Control of Persistent Asthma
  - Tobacco Use Screening
  - Adult Influenza (‘Flu’) Vaccine

- Behavioral Health Integration Domain
  - Screening for Clinical Depression
  - Management of Depression Medication
  - Screening for Unhealthy Alcohol Use
  - Value Based Program Payments

VBP Payments

The VBP is projected to be implemented for at least three years, subject to approved funding through the state and program design by the Centers for Medicare & Medicaid Services (CMS). To address and consider health disparities, an increased payment has been allocated for members diagnosed with substance use disorder, serious mental illness (Schizophrenia, Bipolar Disorder, Other Bipolar Disorder, and Major Depression), or homeless or inadequate housing. Payments are based on Medi-Cal receiving the encounter data, with the design to pay providers based on the National Provider Identifier (NPI) in the rendering or ordering provider field that is an NPI for an individual (Type 1):

- If the rendering or ordering is not completed, the prescriber fields will be used for NPI for an individual (Type 1).
- If the rendering, ordering, or prescribing criteria is not met, the billing provider that is an NPI for an individual (Type 1) is used. If the encounter data does not include an individual (Type 1) NPI, then no incentive payment will be made for the encounter.
DHCS has not yet finalized the payment schedule for 2020. For additional information on VBP program, please see the DHCS VBP website and Alliance website.

**Member Incentives 2020**

**Health Education and Disease Management Programs**

Alliance Medi-Cal members who do not have other health insurance are eligible to participate in member incentive programs. Members need to meet program criteria and must be eligible during the time the service is being provided by their PCP. These incentives are provided in conjunction with the Alliance Health Education and Disease Management programs and are designed to support and encourage members’ efforts for engaging in healthy behaviors that improve their health outcomes. The impact of each incentive will be assessed by the Alliance at the end of the year. Please visit the Alliance Health Education and Disease Management Program page of the Alliance provider website for important information, including required program components, program eligibility, and member incentive for the following programs:

- Healthy Weight for Life Program
- Healthy Moms and Healthy Babies Program
- Healthier Living Program

**Nurse Advice Line Service**

The Nurse Advice Line (NAL) offers 24/7 triage support to direct all Alliance members requiring medical attention to the appropriate level of care, in the appropriate time frame, resulting in decreased ED use for avoidable conditions and improved PCP access. Alliance Medi-Cal Members who call the NAL will be entered into a raffle for a chance to win a $50 gift card.
Listed below you will find a list of forms, along with a brief description for their intended use. To view or download these forms, and for complete instructions on submitting them, please visit the Alliance Form Library.

**Other Forms**

**Claims**

*Comments/Suggestions for the Claims Department* – Providers can use this form to send comments or suggestions to the Alliance Claims Department.

*Corrected Claim Form* – Providers can use this form to submit corrected claims. The form must be filled out and the claim must be attached. Please do not staple the claim to the form as this delays processing time.

*EDI Trading Partner Agreement: All Transaction Types* – This application is used by providers in order to enroll in various ANSI X12 HIPAA compliant EDI transactions, such as 837 professional and institutional Electronic Claims Submission, and others.

*Interested in Electronic Claims Submission?* – Submission of the EDI Trading Partner Agreement begins the electronic claims submission process.

*Reimbursement Rates Form* – Providers can use this form to request reimbursement rate information from the Alliance.

**Finance**

*Credit Balance Report* – This form needs to be filled out quarterly and sent to the Alliance.

*Provider Identified Overpayment Form* – Providers can use this form to report an overpayment made by the Alliance.

*OHC Referral Form* – Providers can use this form to report a member's Other Health Coverage.

*EFT/ACH Authorization Form* – Providers can use this form to receive electronic payments via Electronic Fund Transfer/Automated Clearing House.

*EFT/ACH Authorization Form Instructions* – This document provides instructions on how to complete the Electronic Fund Transfer/Automated Clearing House Authorization Form.

**Grievance**

*Member Complaint Packets (English, Spanish, Hmong)* – These files can be printed out and handed to members who are interested in filing a complaint to the Alliance's Grievance Coordinator.
**Section 19. Forms**

**Need Help with Your HMO? (English, Spanish)** – Flyers from California Department of Managed Health Care describing how members can get help regarding their health plan.

**Health Services**

**Advance Directives Form (English, Spanish)** – These advance directives forms are easy for patients to read and understand.

**Asthma Action Plan (AAP) (English, Spanish, Hmong)** - PCPs may use the form below or their own form to create an AAP for members age 5-64 with a diagnosis of asthma. This form does not need to be submitted to the Alliance.

**CPT/Procedure Code Inquiry Form** – Providers can use this form to check if a CPT code requires prior authorization.

**Provider Change Request (PCR) Form** – Providers can use this form to make simple changes to an existing prior authorization.

**Authorization Status Request** – Providers can use this form to check the status of an authorization request.

**Treatment Authorization Request** – Providers can use this form to request authorization for outpatient services, out-of-area authorized referrals, and durable medical equipment requests.

**Request for Extension of Stay in Hospital** – Providers can use this form for an extension of inpatient hospital stays.

**Long Term Care Treatment Authorization Request** – Providers can use this form to request authorization for long term care.

**Community Based Adult Services (CBAS) Inquiry Form** – Providers can use this form to inquire about CBAS services for Alliance members.

**Consent for Sterilization or Hysterectomy Sample Form** – Providers can use this sample form to obtain consent for sterilization or a hysterectomy. Providers are free to duplicate this form and add their letterhead. For additional information, please see Policy 404-1401 - Sterilization Consent Protocol.

**Comprehensive Perinatal Services Program (CPSP)** - Per Title 22, Section 51348, all contracted providers must perform a comprehensive risk assessment for all pregnant members that is comparable to the American Congress of Obstetricians and Gynecologists (ACOG) and CPSP standards. The Providers can use these forms during an initial prenatal visit, once each trimester thereafter, and at postpartum visits.

**Medi-Cal Provider-Preventable Conditions Reporting Form** - Providers are required to send the completed Department of Health Services (DHCS) 7107 form within five working days of discovery to DHCS, Audits and Investigations Division as instructed on the form. A copy must also be sent to the Alliance Quality Improvement Department via fax. For additional information, please see Policy 401-1305 - Provider Preventable Conditions.

**Medication Management Agreement (MMA)** - PCPs may use this form to create a Medication Management Agreement for their members. PCPs that complete and fax this form to the Alliance may be eligible for payment through our CBI program.
Physician Orders for Life-Sustaining Treatment (POLST) (English, Spanish, Hmong) - This incentive is designed to ensure that conversations on end-of-life planning occur with seriously ill patients, allowing them to choose the treatments they want and helping ensure that their wishes are honored by medical providers.

Prescription Drug Prior Authorization Request Form – Providers can use this form to request prior authorization for medications for In-Home Supportive Services (IHSS) members.

Request for Administrative Member Classification – Providers can use this form to request that an Alliance member be made an administrative member.

Staying Healthy Assessment Order Form – Providers can use this form to order bulk quantities of the Staying Healthy Assessment forms and patient handouts in English, Spanish and Hmong.

Synagis Policy and Medical Necessity Form – Providers who wish to administer Synagis in their office are required to submit the Statement of Medical Necessity along with the prior authorization request. For more information on Synagis, please see Alliance Policy 403-1120 - Synagis.

Transportation – Providers can use Physician Certification Statements of Medical Necessity to request Non-Emergency Medical Transportation (NEMT). Providers can use the Transportation Services Request Form to request transportation services.

Provider Services

Certification Regarding Debarment Suspension, Ineligibility and Voluntary Exclusion – Providers can send this form to the Alliance with their signed Services Agreement.

Certification Regarding Lobbying - Exhibit D (F) Att. 1 and 2 – Providers receiving payments under the Services Agreement of $100,000 or more are required to submit this form to the Alliance.

Locum Tenens Notification Form – Providers can use this form to notify the Alliance of all locum tenens before they render services to Alliance members.

Member Appointment No-Show Notification – Providers can use this form is used to inform the Alliance’s Member Services department that an Alliance member did not keep a scheduled appointment.

Patient Complaint / Grievance Tracking Log – Providers can use this form to track patient requests for Complaint/Grievance Forms.

Provider Applications – If you are interested in becoming an Alliance provider, visit our Join our Network page on the Alliance provider website.

Provider Dispute Form – Providers can use this form to file a dispute with the Alliance.

Provider Information Change Form – Providers can use this form to update contact and practice information, including provider address, phone number, contact information, payment address, and tax ID number.

Reimbursement Rates Form – Providers can use this form to request reimbursement rate information from the Alliance.

Request for Member Reassignment - Forms, procedures, and member notices to be used when requesting member reassignment.