Central California Alliance for Health New Provider Training and Onboarding Long Term Support Services

Updated October 2023

NEW PROVIDER TRAINING

AGENDA:

1. Introduction to the Alliance
2. Member Benefits
3. Fraud Waste and Abuse/ Compliance
4. Authorizations and Referrals
5. Claims
6. Grievances and Disputes
7. Other Services Provided
8. Provider Required Training

Welcome to the Alliance!

Who are we?

- Central California Alliance for Health (the Alliance)
- County Organized Health System
- Serve over 455,000 members in Santa Cruz, Monterey, Merced, Mariposa, San Benito, Counties
- Operate using the Managed Care Model

What programs do we cover?

- Medi-Cal
- Alliance Care IHSS (Monterey)

Alliance Mission, Vision and Values

Our Mission

Accessible, quality health care guided by local innovation.

Our Vision

Healthy people. Healthy communities. (English)

Our Values

EQUITY
Eliminating disparity through inclusion and justice.

INTEGRITY
Telling the truth and doing what we say we will do.

IMPROVEMENT
Continuous pursuit of quality through learning and growth.

COLLABORATION
Working together toward solutions and results.

The Managed Care Model

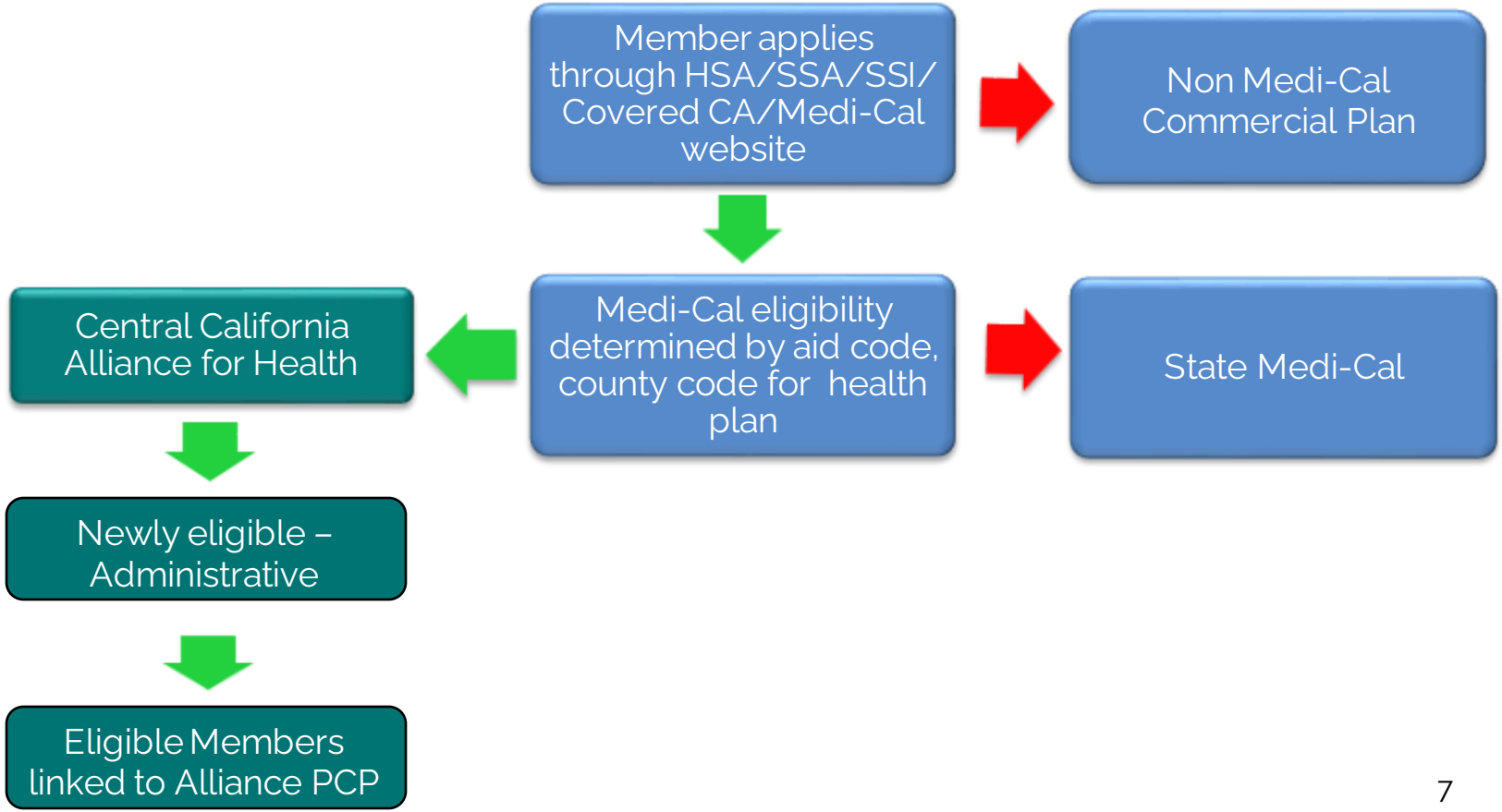
- Members select a **Primary Care Provider** (PCP) who provides a patient-centered medical home.
- PCP is responsible for members' **primary and preventive care** and arranging and coordinating all other aspects of their health care.
- PCPs are family practice, internal medicine, pediatrics or OB/GYNs.
- Eligible members **assigned** ("linked") to a PCP or clinic may only see a specialist (e.g., cardiologist, dermatologist, rheumatologist) if referred by their PCP.

How a Health Plan Works

The Alliance is a health plan that was developed to improve access to health care for lower income residents who often lacked a primary care "medical home" and so relied on emergency rooms for basic services. The Alliance has pursued this mission by linking members to primary care physicians (PCPs) and clinics that deliver timely services and preventive care and arrange referrals to specialty care.

- Member is linked to a PCP clinic after their first initial month
- PCP and member connect for Initial Health Assessment, pending on member needs PCP providers will make referrals to specialist or Allied providers such as Cardiology, Physical Therapy, Sleep providers, Acupuncturist etc.
- Referrals are obtained by PCP fax or member phone call. Specialist/Allied providers review referral and outreach is made.
- If additional visits are required by specialist the specialist is responsible for submitting an authorization for continued care
- PCP office is responsible for ensuring member accesses specialty care

How Members Join the Alliance



Member Eligibility

Prior to patient visit:

1. Verify **eligibility** at every visit
2. Eligible?
3. Is member **linked** to your organization?
4. If yes, go ahead and see the patient

How to verify eligibility?

Provider Portal: Available 24 hours a day. 7 days a week

Member Services :
(800) 700 3874
English: ext. 5505
Spanish: ext. 5508

Alliance automated system:
(800) 700 3874 ext. 5501

Reasons why a member may not be eligible:	Reasons why a member may not be linked to a practice and can still be seen:
• Share of cost (members would become FFS) • Moved out of Alliance service area • Lost eligibility	• State Medi-Cal • Administrative member

Membership Cards

Alliance Cards

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
800-700-3874

Member:
Member ID:
Birth Date:
PCP:

Effective Date:
Program:

24/7 Nurse Advice Line/Línea de Consejos de Enfermeras: 844-971-8907
Dental/Cuidado dental: Medi-Cal Dental Program 800-322-6384
Mental health/Salud mental: Beacon Health Options 855-765-9700
Prescription drugs/Medicamentos recetados: Medi-Cal Rx 800-977-2273
Vision/Visión: Vision Service Plan (VSP) 800-877-7195
TTY Line/Línea TTY: 877-548-0857
www.thealliance.health

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
ALLIANCE CARE IHSS HEALTH PLAN 800-700-3874

Member:
Member ID:
Birth Date:
PCP:

Effective Date:

Copayments: Office Visit: $10 Rx Generic: $5 Rx Brand Name: $15 ER: $25
24/7 Nurse Advice Line/Línea de Consejos de Enfermeras: 844-971-8907
Mental health & substance abuse/Salud mental y abuso de substancias:
Beacon Health Options 800-808-5796
TTY Line/Línea TTY: 877-548-0857
www.thealliance.health

State Medi-Cal Card

Accessibility Standards for Member Appointments

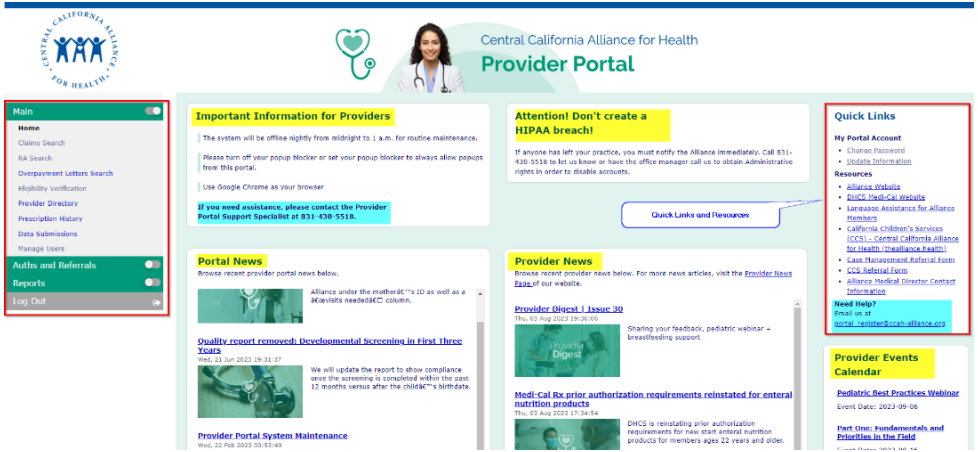
Category	Timely Access Standard
Urgent care appointment for which no prior authorization is required	24 hours
Urgent care appointment for services that do require prior authorization	96 hours from request
Non-urgent, primary care – including first pre-natal visit No authorization required	10 business days
Non-urgent, non-physician mental health providers	10 business days
Non-urgent follow-up appointment with a mental health care (non-physician provider) or substance use disorder provider.	10 business days from prior appointment
Non-urgent, Specialist care	15 business days
Non-urgent, ancillary services	15 business days
Mental Health Care	Refer to Carelon for screening. Mild to moderate levels of care will be referred to a Carelon provider. Severe levels of care referred to county mental health.

Provider Portal

The **Provider Portal** is an online resource that has many valuable functions. It's a secure way to transfer information between the Alliance and the providers.

Some of the functions include:

- Member Eligibility
- Search and Submit Requests
- Claims information
- Reports
- Additional Resources



The Alliance Provider Portal Login Page: https://provider.portal.ccah-alliance.org/

Using the Provider Portal: https://thealliance.health/for-providers/provider-portal/using-the-provider-portal/

Provider Portal New Account Request Form: https://thealliance.health/for-providers/provider-portal/provider-portal-account-request-form/

Provider Portal FAQs: https://thealliance.health/for-providers/provider-portal/using-the-provider-portal/provider-portal-frequently-asked-questions/

MEMBER BENEFITS

1. Benefits
2. Subcontracted Benefits
3. Benefits Not Covered

Member Benefits

- Primary care
- Specialty care
- Allied services (PT, OT, ST, Acupuncture, Chiro)
- Durable Medical Equipment
- Self-referred services (OB Sensitive Services)
- Physician Administered Drugs
- Emergency & Urgent visits
- Inpatient and outpatient hospital care
- Diagnostic services (lab, x-ray, imaging)
- Enhanced Care Management (ECM)
- Community Supports
- Doula Services

Link: Benefit descriptions can be found in the Member Handbook on the Alliance website

Subcontracted Member Benefits

- **Vision**
  - Covered through Vision Services Plan (VSP)
  - Toll-free access line Monday through Friday from 6:00 am to 7:00 pm Phone: 800-877-7195
- **Medi-Cal Mental Health**
  - Carelon Behavioral Health is subcontracted to provide outpatient mental health services for Alliance members
  - Toll-free access line 24 hours a day, 7 days a week | Phone: 855-765-9700
- **IHSS Mental Health (Monterey)**
  - Carelon Behavioral Health manages outpatient and inpatient mental health. There is no referral to county
  - Toll-free access line 24 hours a day, 7 days a week | Phone: 855-765-9700

Benefits Not Covered by the Alliance

- Dental Services (Denti-Cal)
- Inpatient Mental Health Services (State Medi-Cal)
- Substance Use Disorder Treatment Services (Co. BH and State Medi-Cal)
- Local Education Authority Services (Regional Centers)
- Outpatient prescription drugs (Medi-Cal RX)
- Serious Mental Illness Health Services (County BH Dept)
- Institutional long-term care (for stays longer than the month of entry)

AUTHORIZATIONS AND REFERRALS

1. Referral Process
2. Authorization Process
3. California Children's Services/ Whole Child Model Program
4. Prescription and Physician Administered Drug Authorization Requests

Referral Process: Out of Network and Non-Contracted Providers

1. The provider completes:
   - **A Referral** using the provider portal
   - **A TAR Form** submitted via fax to 831-430-5850
2. The Alliance will **fax authorization correspondence** to the requesting provider with the following:
   - **Approval:** Request has been reviewed and approved.
   - **Deferral:** Additional time to process authorization requests for Medi-Cal members beyond the fourteen (14) calendar days of receipt of request, but only where the Member or the Member's provider requests additional time or the Alliance can provide justification for the need for additional information, and when this is in the best interest of the member.
   - **Denial:** Denial determinations may occur at any time in the course of the authorization review process. There are a variety of reasons that a request may be denied, including but not limited to, either a lack of medical necessity or the service is not a Covered Service.
   - **Void:** Alliance staff may void an authorization request, within the first five business days for routine requests, for reasons including:
     - -Member is not eligible with the Alliance
     - -Duplicate authorization request
     - -No authorization is required
     - -Administrative void; Invalid authorization submission, i.e., when PCPs submit authorizations for unlinked members.
     - -Member has other health care coverage
     - -Provider or member requests to withdraw or void request
     - -Requests remain incomplete, following the Alliance's outreach to the provider to obtain valid and correct information, or after unsuccessful attempts to contact the provider within the required timeframe
3. Prior authorization is <u>not</u> required for emergency care. A direct referral from the Emergency Department to out-of-network specialists is allowed for urgent surgical, orthopedic, acute pain management, and ophthalmologic conditions.

Helpful Hints:
Referrals to Out of Network and Non-Contracted Providers

- For providers outside of Mariposa, Merced, Monterey, San Benito and Santa Cruz Counties. The member's PCP or Specialist may initiate the referral process.
- The PCP completes **and signs** the referral either by using an Alliance TAR form located on our website or via the Provider Portal.
- The request must include:
  - ✓ Explanation of medical necessity
  - ✓ Failed treatment attempts prior to referral
  - ✓ Reasons why care can not be accessed locally
  - ✓ Contact name, department, phone and fax number

Please note: Clinical documentation supporting medical necessity must be submitted at the time of authorization submission or authorizations will be voided.

Out of Network and Non-Contracted Providers: **Referral Form**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

SERVICE CATEGORY

5

CONFIDENTIAL PATIENT INFORMATION

FOR F.I. USE ONLY

CCN

F.I. USE ONLY

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

REQUEST IS RETROACTIVE ? YES NO

PROVIDER PHONE NO. Your number

FAX # Your Fax

PROVIDER NPI# Enter NPI

PROVIDER NAME AND ADDRESS

- Note the servicing provider name
- Include the facility where the servce will be rendered

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

Enter the requesting providers facility name and contact information.

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.)

Enter all member info

PATIENT IDENTIFICATION NO.

Enter member Medi-Cal ID

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ( )

SEX

AGE

DATE OF BIRTH

HOME

BOARD & CARE

SNF/ICF

ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION:

CURRENT ICD- 10CM CODE

MEDICAL JUSTIFICATION:

Explain medical necessity for out of area care, particularly if services are available in network. Provide info on failed treatment attempts prior to referral. Provide date of last PCP visit. Attach consultation reports/ pertinent documentation.

FOR STATE USE

PROVIDER: YOUR REQUEST IS:

APPROVED AS REQUESTED

DENIED

DEFERRED

APPROVED AS MODIFIED

BY:

PHC CONSULTANT'S NAME

DATE

REVIEW COMMENT INDICATOR

COMMENTS / EXPLANATION

ADDED REMINDERS

Do not make copies of blank forms.

Do not send the same request twice

When checking auth status use the pending auth # if known.

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/ UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1				Define your request for	No CPTs needed for out of area request			
2				services, i.e., consultation				
3								
4								
5								
6								

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

Form must be signed and dated

SIGNATURE OF PHYSICIAN OR PROVIDER

TITLE

DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

FROM DATE

TO DATE

TAR CONTROL NUMBER

OFFICE

SEQUENCE NUMBER

PC

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

The referral from is available to be completed electronically on the Provider Portal.

Authorization Requests

A Treatment Authorization Request (TAR)/ Authorization is submitted by the requesting or servicing provider requesting authorization for services from the Alliance.

The provider has ensured that the member meets state eligibility criteria.

Authorizations must be completed and submitted on the Provider Portal or faxed.

- Authorization must include:
  - ✓ Medical justification
  - ✓ Documentation of recent member situation to justify request
  - ✓ Copies of relevant member info
  - ✓ Must be signed and dated by provider
  - ✓ Contact name, phone and fax number is required
  - ✓ Clinical documentation supporting medical necessity must be submitted at the time of authorization submission or authorizations will be voided

Treatment Authorization Request (TAR) Form

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

SERVICE CATEGORY

5

CONFIDENTIAL PATIENT INFORMATION

FOR F.I. USE ONLY

CCN

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

F.I. USE ONLY

PROVIDER PHONE NO. Your number

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

- Complete with where the servce/ treatment will be rendered

FAX # (Your Fax

PROVIDER NPI# Enter NPI#

PATIENTS AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

- Enter requesting providers facility name and contact information.

FOR STATE USE

NAME AND ADDRESS OF PATIENT

Enter all Member info

PATIENT IDENTIFICATION NO.

Enter Member Medi-Cal ID

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER AREA

DIAGNOSIS DESCRIPTION:

CURRENT ICD-10CM CODE

MEDICAL JUSTIFICATION: ADDED REMINDERS

Incomplete TARs take longer to process

Do not make copies of blank forms.

Do not send the same TAR twice.

When checking TAR status use the pending Auth # if known

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1						Enter CPT Code	How many	
2								
3								
4								
5								
6								

Form must be signed and dated

This form is also available to be completed electronically on the Provider Portal at https://thealliance.health/for-providers/provider-portal/

This form is also available on the Alliance Provider website to be faxed 831-430-5850 https://thealliance.health/wp-content/uploads/Treatment_Authorization_Request.pdf

Helpful Hints: Authorizations

When a Treatment Authorization Request (TAR) is needed (for all providers):

Common Medical Services:

- Referrals to out of service area provider/facility
- MRIs and unlisted CT
- Non-formulary drug
- DME supplies
- Pediatric Therapies
- Podiatric treatment
- Outpatient surgery
- All Inpatient stays
- Sleep Studies

A Procedure Code Lookup Tool is available on our website for Non-Contracted Providers https://thealliance.health/for-providers/provider-portal/procedure-code-lookup-tool/

Specialist to Specialist Referrals:

- Specialists can refer directly to other specialists without a PCP referral. Specialists must submit an Alliance TAR form located on our website or via the Provider Portal.

Outpatient Prescription Drug Authorization Requests:
Submit to Medi-Cal Rx for Pharmacy Claims

- Prior authorization requests for **pharmacy claims** can be submitted to **Medi-Cal Rx** in the following ways:
  1. Medi-Cal RX Provider Portal
  2. Cover My Meds
  3. PA form (DHCS 6560) and submit via fax or mail:
     - Fax: 800-869-4325
     - Mail to:

       Medi-Cal Rx Customer Service Center
       ATTN: Provider PA Requests
       P.O. Box 730
       Rancho Cordova, CA 95741-0730

- Medi-Cal RX contract Drug List can be found here

- Additional information is available on the **Medi-Cal Rx website** or by calling Medi-Cal RX at 800-977-2273

Physician Administered Drug (PAD) Authorization Requests: Submit to The Alliance

- Prior authorization requests for physician administered drugs (**PADs**) can be submitted to **The Alliance** in the following ways:
  1. Provider Portal *preferred method
  2. Fax one of these forms to (831) 430-5851:
     - Prescription Drug Prior Authorization Form or
     - Treatment Authorization Request (TAR) form

- Whether a PAD requires a prior authorization or not can be found here

- If a PAD requires a prior authorization the criteria can be found here

- Additional information can be found at www.thealliance.health or by calling the Alliance pharmacy department at (831) 430-5507

STRETCH BREAK

LONG-TERM SUPPORT SERVICES (LTSS)

- Overview
- Resident rights
- Continuity of Care
- Leave of Absence & Bed Holds
- Billing Practices & Balanced Billing Prohibitions
- Provider Payment
- Clinical Documentation
- Benefits Coordination
- Alliance LTSS Liaisons

SNFs, ICF/DD, ICF/DD-H, ICF/DD-N, Subacute

- As an outcome of CalAIM, the Alliance is responsible for providing the following services:
  - Skilled Nursing Facilities
  - Intermediate Care Facilities for the Developmentally Disabled
  - Adult and Pediatric Subacute facilities
- LTC staff must complete appropriate training on leave of absence and bed hold requirements, including knowledge of the required clinical documentation to exercise these rights

Resources

- APL 23-004 - Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)
- APL 23-023 - Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 - Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- ICF Resource Guide

Resident Rights

Members keep all of their basic civil or human rights and liberties when admitted to a nursing home. Because these rights are so important, both federal and state regulations list nursing home residents' rights in detail and require the California Department of Public Health (CDPH) staff that inspect nursing homes to decide whether each home is protecting and promoting residents' rights. Please see the CDPH website for more information.

The rights included in the regulations apply to all areas of your life in the nursing home. These rights relate to general categories which include:

- Admissions rights
- Quality of life
- Visitors
- Privacy & confidentiality
- How to spend your time
- Grievances
- Participation in groups & activities
- Living accommodations
- Quality care
- Protection of money & possessions
- Medical care & treatment
- Freedom from abuse
- Transfer and discharge rights
- Resident records
- Free choice
- Participation in care planning
- Freedom from physical & chemical restraints

Continuity of Care Determinations

- Alliance ensures provision of Leave of Absence and Bed Hold requirements of California Code of Regulations Title 22.
- Alliance provides Continuity of Care (CoC) for members transferred from SNF to Acute hospital.

Resources

- Policy 404-1524 Long Term Care for Medi-Cal Members
- Alliance Policy 404-1114
- Policy 404-1525 – Skilled Nursing Facility Program for Medi-Cal

Leave of Absence & Bed Holds

- Leave of Absence (LOA) and bed hold policies state members must be allowed to return to the same home where the Member previously resided if it is the Member's preference.
- LTCs must notify the Member or the Member's authorized representative in writing of the right to exercise the bed hold provision.
- If a Member does not wish to return to the same LTC following a LOA or approved bed hold period, the Alliance will provide care coordination and transition support, including working with the assigned entities, in order to assist the Member to identify another LTC within the Network that can serve the Member.
- Other entities, such as Regional Centers, may take the lead on discharge and transition planning if the Member wishes to transition to a non-Medi-Cal funded living situation with input from other stakeholder such as the hospital, the original LTC, and the Alliance.
- The Alliance will take the lead on discharge and transition planning if the Member chooses to transition to a different Medi-Cal level of care, in collaboration with other entities, as needed.
- The Alliance provides Continuity of Care (CoC) for members transferred from LTCs to Acute hospital.

Title 22 CCR sections 51535 and 51535.1

Billing Practices and Balance Billing

Balance Billing

- Providers cannot bill Medi-Cal members for any unreimbursed amount including a deductible/coinsurance or copay amount.
- Please refer to the Claims Section of this training for more information
- Please contact Alliance Claims Department for Support (831) 430-5503

LTC Code & Claim Form Conversion

- Effective February 1, 2024, the Department of Health Care Services (DHCS) will retire the use of Long-Term Care (LTC) local service codes and the Payment Request for Long Term Care (25-1) local form.
- These local procedure codes will be replaced by National Uniform Billing Committee (NUBC) data elements and the UB-04 claim form or an electronic 837I claim transaction.

https://thealliance.health/ltc-codes-claims/

https://thealliance.health/for-providers/resources/claims/

Provider Payment

- The Alliance partners with Change Healthcare and Echo Health Inc. for provider payments

- Three Provider Payments
  1. Virtual Credit Care
  2. Paper Check
  3. EFT

Resources

- ECHO Enrollment Page

- ECHO Provider Support
  (888) 983-5574

- Alliance Claims Dept
  (831) 430-5503

Clinical Documentation

- Medical Necessity is determined by documentation reflecting current care needs.
- If documentation is lacking, the Alliance will request additional, supporting documents to substantiate Medical Necessity.
- To prevent an individual's inappropriate nursing facility admission and retention of individuals, federal law requires proper screening and evaluation before placement.
- These Preadmission Screening and Resident Review (PASRR) requirements are applicable for all Medicaid-certified nursing facilities for all admissions (regardless of payer source).
- The PASRR process is required to ensure that individuals who may be admitted into a nursing facility for a long-term stay be preliminarily assessed for serious mental illness and/or intellectual/developmental disability or related conditions.
- The Alliance will work with providers to obtain documentation validating PASRR process completions.

Benefits Coordination

- CalAIM seeks to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility through benefit standardization.
- Benefit standardization will help ensure consistency in the benefits delivered by Medi-Cal managed care and FFS statewide.
- The Alliance will coordinate benefits with Other Health Coverage (OHC) programs or entitlements in accordance with APL 22-027, Cost Avoidance and Post-Payment Recovery for Other Health Coverage, or any superseding APL, including recognizing OHC as the primary payer, and the Medi-Cal program as the payer of last resort.
- The Alliance will coordinate benefits by exercising cost avoidance; billing OHCs, such as Medicare or private health coverage, as primary when the coverage is known; and conducting post-payment recovery for the reasonable value of the services if the OHC is identified retroactively, if the Member has an OHC indicator of A, or if the service is required to be pay and chase.
- Additional information is available in APL 22-027, or any superseding APL.
- The existence of OHC must not be a barrier to accessing LTC services.

LTSS Liaisons ~ Provider Services Relations Team

Full Name	Title	Email	Phone Number	County
Angelique Milhouse	Provider Relations Liaison	AngelM@ccah-alliance.org	(831) 430-5531	All
Jim Lyons	Provider Relations Manager	jlyons@ccah-alliance.org	(831) 430-5774	All
Mary Bahni	Provider Relations Assistant	MaryB@ccah-alliance.org	(831) 430-5540	All
Minerva Galvan	Senior Provider Relations Representative - ECM	mgalvan@ccah-alliance.org	(831) 430-1468	All
Cleo Morello	Provider Relations Representative	cmorello@ccah-alliance.org	(831) 430-5744	All
Anna Santos	Provider Relations Representative	asantos@ccah-alliance.org	(831) 430-2616	Mariposa
Cynthia Balli	Provider Relations Supervisor	cballi@ccah-alliance.org	(209) 381-7394	Merced
Jacqueline Morales	Provider Relations Representative	jmorales@ccah-alliance.org	(209) 381-7370	Merced
Suzie Vargas-Tombs	Senior Provider Relations Representative	svargas-tombs@ccah-alliance.org	(209) 381-5346	Merced
Angelica Baltazar	Provider Relations Supervisor	AngelicaC@ccah-alliance.org	(831) 755-6097	Monterey
Berenice Cortez	Provider Relations Representative	bcortez@ccah-alliance.org	(831) 755-6046	Monterey
Jasmin Galindo Romero	Providers Relations Representative	jromero@ccah-alliance.org	(831) 430-4122	Monterey
Natalie Anthony	Senior Provider Relations Representative	nanthony@ccah-alliance.org	(831) 755-6028	Monterey
Alissa Gil	Provider Relations Representative	agil@ccah-alliance.org	(831) 755-6055	San Benito
Ana Marta	Provider Relations Representative	amarta@ccah-alliance.org	(831) 430-1484	Santa Cruz
Heidi Seago	Senior Provider Relations Representative	hseago@ccah-alliance.org	(831) 430-5538	Santa Cruz
Maribel Quintero	Provider Relations Supervisor	mquintero@ccah-alliance.org	(831) 755-6072	Santa Cruz
Michelle Perez	Provider Relations Representative	miperez@ccah-alliance.org	(831) 430-5764	Santa Cruz

CLAIMS

1. Claims Department Overview
2. Encounter Data
3. Claim Form Samples
4. Clean Claims
5. How and Where to Submit
6. Timely Filing
7. Remittance Advice
8. Resolving Denials
9. Alliance Portal vs Change Echo
10. Electronic Data Interchanges

Claims Department

- The Claims department is where claims come to be adjudicated
- Processed claims will be communicated on a "Remittance Advice" document that is sent to the provider in approximately 30 days from received date
- The Claims Customer service team is available to answer your questions and help you resolve claims issues.

Claims Department : Alliance Website

Resources

- **COVID-19**
- **Claims**
  - View/Submit a Claim
- **Forms**
- **News**
- **Provider Directory**
- **Provider Manual**
- **Timely Access to Care**
- **Training**

Claims

The Alliance Claims Department is committed to processing your claims as quickly and accurately as possible.

We work with DHCS (Medi-Cal and Electronic Data Systems) to maintain the most current Medi-Cal benefits and allowances.

For the most current billing guidelines and updates, please reference the Claims section of the Provider Manual.

EXPAND ALL

- Claim Questions
- Electronic Data Interchange
- Remittance Advice Information
- Supplemental Payments
- ICD-10 Information and Resources

Contact Provider Services

General	831-430-5504
Claims Billing questions, claims status, general claims information	831-430-5503
Authorizations General authorization information or questions	831-430-5506
Authorization Status Checking the status of submitted authorizations	831-430-5511
Pharmacy Authorizations, general pharmacy information or questions	831-430-5507

Provider Resources

- Provider Portal

Claims Resources

- Self-Serve Password Reset for RTEDI

Latest Provider News

Provider e-Newsletter

Provider Newsletter | Issue 28
February 24, 2022

Link: https://thealliance.health/for-providers/resources/claims/

Encounter Data and Clean Claims

Encounter data

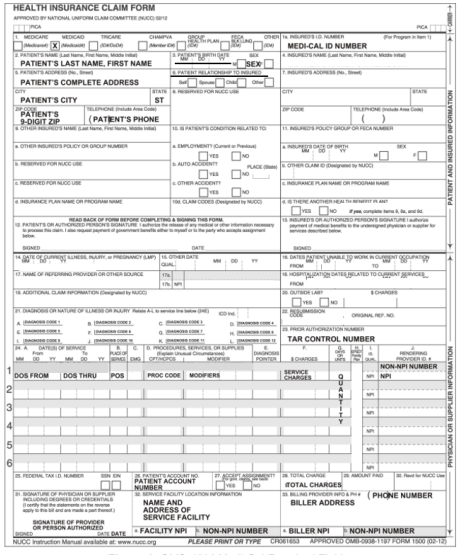
- Encounter data is information submitted by health care providers, such as doctors and hospitals, that documents both the clinical conditions they diagnose as well as the services and items delivered to beneficiaries to treat these conditions
- Submitted thru the claims process

Clean Claims

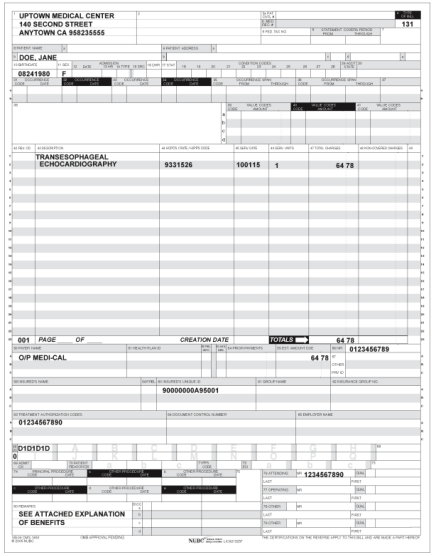
- A clean claim is defined as a claim that contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability
- It is one that can be processed without obtaining additional information from the provider of the service or from a third party.
- It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity

Claim Forms

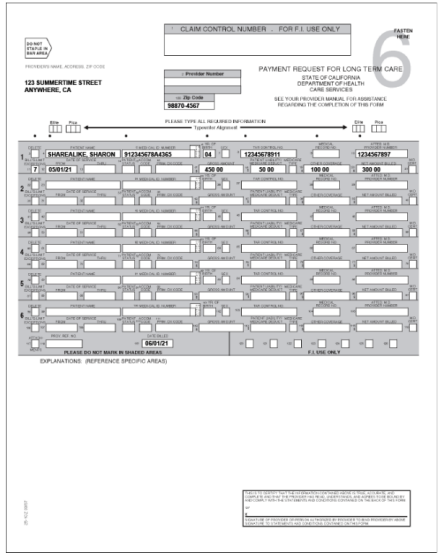
The Alliance accepts three standard claim forms:



The CMS-1500 form is used by a non-institutional provider to bill for encounters and services such as office visits, surgery, radiology, laboratory, or other physician or health care professional services.



The UB-04 form is used by institutional facilities such as hospitals or outpatient facilities to bill for services such as surgical supplies, radiology, laboratory, or other facility services.



The 25-1 claim form is used to bill for long term care services such as those provided by a skilled nursing facility

How & Where to Submit Claims

- Providers may submit hard copy claims by mail or claims may be submitted electronically through a clearing house (i.e. Office Ally).
- The Alliance accepts the following claim forms CMS1500, UB04, and the 25-1C.
- Medi-Cal (including Medi-Cal members with CCS eligibility) ATTN: CLAIMS Central California Alliance for Health, PO Box 660015 Scotts Valley, CA 95067-0015
- Alliance Care IHSS ATTN: CLAIMS Central California Alliance for Health 1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066
- The Alliance uses Medi-Cal guidelines to process claims www.medi-cal.ca.gov
- The Alliance uses the current year AMA CPT and Healthcare Common Procedure Coding System (HCPCS) along with ICD-10 diagnosis codes and some "Local Codes" that can be found in the Medi-Cal Manual at: www.medi-cal.ca.gov. For additional resources, see the ICD-10 section on our website.

https://thealliance.health/for-providers/resources/claims/

Timely Filing

Claims must be received within 6 months from the date of service to be considered timely and payable at 100% of the allowed amount.

- Claims received 7-9 months after the date of service will be reimbursed at 75% of the allowed amount.
- Claims received 10-12 months after the date of service will be reimbursed at 50% of the allowed amount.
- Claims received more than a year after the date of service will be denied.

Remittance Advice

Page 1 of 13

Electronic Payment Clearinghouse
Central California Alliance for Health
1600 Green Hills Rd Ste. 101
Scotts Valley CA 95066

Tran Nbr: 245625670
Card Value: 19,418.45
Date: 01/18/2022

QuicRemit® Prompt Payment Services
CVV2 XXX
XXXX XXXX XXXX 1234
VALID THRU 04/22
VISA
ECHO Health, Inc.

Provider Name
Address
City, State, Zip

Questions Regarding This Method of Payment? Visit echovcards.com

Your name, Provider Name d Tax ID have been verified by the IRS.

Provider Name
Address
City, State, Zip

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
REMITTANCE ADVICE
Provider NPI

Tax ID:
Check #:
Check Date:

Patient Claim# Line#	Service Date From	To	Proc	Mod	Patient Acct # Qty Allowed	Amount Billed	Subscriber # Amount Allowed	Not Covered	Rendering Prov Patient Resp	Copay	Other Carrier Amount	Contract Adjust	Interest Net Paid	Explain Codes
Member Last name, First					Your Internal Acct #		Member ID		Provider Name				$0.00	
Claim Number					Plan: Medi-Cal									
0103	12/3/21	12/3/21	S5170		14	$99.40	$99.40	$0.00	$0.00	$0.00	$0.00	$0.00	$99.40	
0203	**12/11/21**	**12/11/21**	**S5170**		**14**	**$99.40**	**$99.40**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$99.40**	
Claim Total:						**$198.80**	**$198.80**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$198.80**	
INTEREST PAYMENT														
CLAIMS PAYMENT													**$19,418.45**	
TOTAL PAYMENT						**$19,816.05**	**$19,418.45**	**$397.60**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$19,418.45**	

Summary Of Explanation Codes

Explanation Code	Description
30	30-DENIED: PRIOR AUTHORIZATION NOT OBTAINED FROM PROVIDER FOR PROCEDURE
34	34-THIS IS A DUPLICATION OF A PREVIOUS CLAIM
54	54-PROCEDURE CODE INVALID FOR PROVIDER TYPE AND/OR NUMBER

- a.k.a. Explanation of Benefits (EOB)
- a.k.a. Explanation of Provider Payment (EPP)
- Issued by Change - Echo

Note: Initial payment is always made by Virtual Credit Card. Please let an Alliance representative know if you would like to opt out of VCC in favor of a paper check for your first payment. We will need your NPI and your Tax ID at the time you make your opt out request. This does not apply if you currently receive payments from the Alliance.

Link: https://thealliance.health/wp-content/uploads/RA_Guide.pdf

Resolving Denials

- **Review your EOB**
- **Contact the Claims Department**

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
- ✓ Provider NPI

- **Submit Corrected Claims**

Use Box 19 on the CMS 1500 and Box 80 of the UB-04 for documentation see policy 600-1009

Differences Between Alliance Portal vs Change Echo

Change - Echo

- Owned and maintained by the vendor Change - Echo
- The site to view and pull RA's and check information
- Requires a log in given by Change – Echo
- 888-983-5574
- Providerpayments.com

CCAH Provider Portal

- Owned and maintained by CCAH
- The site to check member eligibility, auth status and claim status
- Requires a log in given by CCAH
- thealliance.health

Electronic Data Interchange FAQs

Q: How do we sign up for Electronic Claims submission with CCAH?
A: You will need to complete this form to sign up for Electronic Claims submission with CCAH: https://www.ccah-alliance.org/aspnetforms/ProviderECSForm.aspx

Q: How do I know whether I am signed up for Electronic Claims submission?
A: Upon receipt of your completed Electronic Claim submission form, you will receive confirmation of your setup from the CCAH EDI team in approximately 2-5 business days.

Q: How long does the Electronic Claims submission process take?
A: The setup process takes approximately 2-5 Business days.

Q: How do I change Clearing Houses?
A: If you are currently setup to send Electronic Claims with CCAH, and need to change Clearing Houses, please submit a new setup form. The EDI team will review and respond within 2-5 business days.

Q: I'm already signed up with another Clearing House, do I need to sign up again to connect to CCAH?
A: Yes, a new setup will be required to ensure your setup can successfully pass through the Clearing House to reach CCAH. You will need to complete this form to sign up for Electronic Claims submission with CCAH: https://www.ccah-alliance.org/aspnetforms/ProviderECSForm.aspx.

Electronic Data Interchange FAQs Continued

Q: How do we sign up to receive an Electronic Remittance Advice (ERA)?
A: To enroll in ERA, contact our partner ECHO Health at https://enrollments.echohealthinc.com/EFTERAInvitation.aspx?ReturnUrl=%2f or call (888) 834-3511.

Q: What is the CCAH Payer ID?
A: The two Clearing Houses used most often by the Alliance are Office Ally and Change Healthcare.
•The Payer ID for Office Ally is CCA01 (Professional and Institutional)
•The Payer IDs for Change Healthcare are SX169 (Professional); 12K82 (Institutional)

Q: Can I connect to CCAH using my own Clearing House (Clearing House that is not Office Ally)?
A: CCAH connects to many Clearing Houses. Upon enrollment setup, CCAH will verify if the provided Clearing House can be connected to. If a Clearing House is unavailable, a provider can still have the option to connect with EDI from your Clearing House via Office Ally or you may contact edisupport@ccah-alliance.org if interested in submitting directly to us.

Q: Is there a contact for EDI assistance at CCAH?
A: edisupport@ccah-alliance.org

GRIEVANCES AND DISPUTES

1. Discrimination Grievances
2. Provider Responsibility
3. Provider Disputes Instructions

What is a Grievance or Appeal?

Member Grievance	• **Any expression of dissatisfaction**. Complaint about Alliance (or provider) benefits or services: quality of care, quality of service, long wait times, or communication issues.
Member Appeal	• When a member does not agree with an Alliance decision to deny or change services. Also called an Adverse Benefit Determination (ABD)
State Fair Hearing	• A formal process members may request when they do not agree with an individual Appeal decision. Medi-Cal members must first file an appeal with the Plan.

Discrimination Grievance

Discrimination Grievances have additional requirements as outlined by the Department of Health Care Services (DHCS) Office of Civil Rights (OCR) division.

When a member alleges a discrimination grievance, the Provider must ensure to include additional information listed to below:

- ✓ Response must include the provider's contact **name** and **direct contact information** (phone/email) of the person preparing the response
- ✓ Initiate an internal review.
- ✓ Provide the Alliance with a **written response** to the members allegation including the findings of your internal review within 10 days
- ✓ Include supportive documents such as:
  - ✓ Non-Discrimination Policies
  - ✓ Dates of Non-Discrimination training

Provider Responsibility: Member Grievance

Receive Alliance Request

- First, ensure a designated staff member will review and timely respond to an Alliance request

Internal Review

- Investigate all issues raised within a member complaint
- Review appropriate records, interview staff and provide any supporting documents

Action to Resolve

- Initiate a resolution or reasonable action suggested by Alliance staff to help resolve a member complaint
- **Important*** Providers may not retaliate or discharge a member for raising a complaint

Respond to the Alliance

- Send a response which addresses all relevant issues raised within the member complaint by the requested due date, typically **within seven (7) days** of the request.
- *note additional requirements for discrimination grievances, including supportive documents such as policies and non-discrimination training dates.

Link: Provider Manual - Central California Alliance for Health (thealliance.health)

Provider Disputes

Prior to filing an inquiry or dispute, providers should **contact a Claims Customer Service Representative** to identify whether their claim denial issue can be addressed immediately over the phone.

The Alliance has a two-level process to resolve Provider disputes. A Provider Inquiry (level 1) or a Dispute (level 2), for more information review the Provider Inquiry and Dispute Resolution policy #600-1017.

Disputes regarding authorizations requiring review of a medical director are created as Level 2 dispute and reviewed a second time by a different Medical Director or clinical designee to the individual that made the initial review. The initial review of the authorization by a Medical Director is considered to be the first level review.

Provider Disputes Instructions

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.

Providers must file Inquiries and Disputes in writing, either by mail or fax for a hard copy, or by email for electronic

Information about the resolution process and the Provider Inquiry Form (PIF) are available on the Alliance website and in the Alliance's Provider Manual. The Provider Inquiry form contains all our contact information.

It is important to enter all Provider contact information on the PIF so we can ensure the resolution is received by the provider timely.

Ensure there is a clear explanation of the issue in question and the result the provider is expecting when filing a Provider Inquiry.

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.

OTHER SERVICES PROVIDED

1. Enhanced Care Management/ Community Supports
2. Requesting Transportation
3. Language Assistance Services
4. Nurse Advice Line (NAL)

CalAIM Enhanced Care Management and Community Supports

CalAIM is a multi year DHCS initiative to improve the quality of life and health outcomes for Medi Cal beneficiaries by implementing broad delivery system, program, and payment reforms.

Enhanced Care Management (ECM)	Community Supports
• The ECM benefit will provide intensive whole-person care management and coordination to help address the clinical and nonclinical needs of Medi-Cal MCP's highest risk members. • MCPs will and oversee ECM benefits, identify target populations and assign them to ECM Providers who will be responsible for conducting outreach and coordinating and managing care across physical, behavioral and social service providers. • ECM services will be community-based with high-touch, on-the ground, face-to-face, and frequent interactions between members and ECM Providers.	• Community Supports are cost-effective, health-supporting and typically non-medical activities that may substitute for State Plan-covered services. • DHCS plans to authorize 14 Community Supports categories, including housing transition and navigation services, respite care, day habilitation programs, and nursing facility transition support to Assisted Living Facilities or a home. • Optional to MCPs - Highly encouraged by DHCS

Referrals for ECM/ CS

No wrong door approach

The Alliance will accept requests for ECM/ CS from:

- Members interested in receiving ECM/ CS or their family members, guardian, authorized representative, caregiver, and/or authorized support person(s);
- Behavioral Health Providers;
- Social Service Providers;
- ECM Providers;
- Other Providers in the Alliance's contracted network;
- Community-based entities, including those contracted to provide Community Supports; and
- Other Providers not listed above.

Referral Process for ECM / CS

1. The member or representative:
   - **Can complete a Referral Form** either using a web-based form
   - **Can call** and a member of the ECM team will walk through form
2. The provider completes:
   - **A Referral Form** using a web-based form

   Enhanced Care Management (ECM) and Community Supports Provider Referrals - Central California Alliance for Health (thealliance.health)
   - **A TAR Form** (fax or email return)
   - **Authorization through the provider portal**
   - **Can call** and a member of the ECM team will review above processes
3. The Alliance will **fax authorization correspondence** to both the servicing and requesting provider.
   - Approval
   - Denial
   - Void
   - Status Change

Requesting Transportation

Alliance Transportation
Quick Reference Guide

NMT - Non-Medical Transportation
No Special Medical Assistance Needed

vs.

NEMT - Non-Emergency Medical Transportation
Special Medical Assistance Needed

Ambulance, wheelchair accessible vehicle or litter van.

Public bus system (bus pass), ride share or private vehicle.

NMT is for Alliance members who can enter and disembark from a vehicle independently. Physician certification statement (PCS) form not valid for this service. Alliance assessment and approval is required.

Fax requests not accepted. Members must call the Alliance 5-7 days prior to make arrangements.

For assistance call: **800-700-3874, ext. 5577**

NEMT is for Alliance members who need special medical equipment while traveling to/from an approved appointment. Submission of a Physiciancertification statement (PCS) form is required for eligibility. Form available at: https://www.ccah-alliance.org/Form%20Library/PCS_NEMT_Form.pdf

For assistance call: **800-700-3874, ext. 5640**

HEALTHY PEOPLE. HEALTHY COMMUNITIES.
www.thealliance.health

06-2021

Alliance Transportation
Quick Reference Guide

Providers can use the link below to access the electronic version of the non-emergency medical transportation (NEMT) request form for Alliance members.

Link: https://thealliance.health/wp-content/uploads/Transportation_Services_Request_Form.pdf

Language Assistance Services

Telephonic Interpreting

- Available 24/7 to support members at all points of contact
- No prior approval needed
- Over 200 foreign languages

Face-to-Face Interpreting

- For use when the following situations are present:
  - Members who are deaf or hearing-impaired.
  - End-of-life issues.
  - Abuse or sexual assault issues.
  - Complex procedures or courses of therapy.
- Prior approval is required to access all face-to-face interpreter services.
- American Sign Language (ASL) is available to deaf or hard-of-hearing members for all Alliance covered services.

Nurse Advice Line (NAL)

Nurse Advice Line

Feeling sick and have questions?
Call 844-971-8907 (TTY: Dial 711)
to talk to a nurse.

If you are having a medical emergency, call 911 or go to the nearest emergency room.

What is the Nurse Advice Line?
The Nurse Advice Line is a service available to all Alliance members. You can call if you have questions about your health or your child's health. A registered nurse will help you with what to do next.

The service is available **24 hours a day, 7 days a week** at no cost to you.

When do I call the Nurse Advice Line?

Call the Nurse Advice Line when:

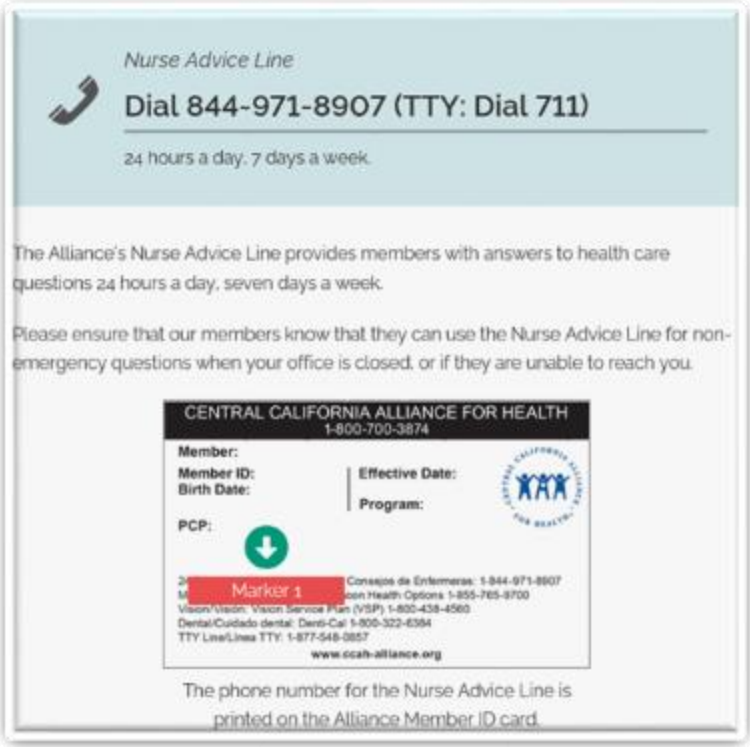
- You or your child is sick, and you cannot reach or get an appointment with your doctor.
  - Examples: Your child has a fever or rash, is vomiting, or your baby's crying is unusual.
- You are not sure if you should go to the emergency room.
- You have questions about your health or your child's health.
- You are under 18 years old and want to talk in private about your health concerns.

When you call:
If you have your Alliance Member ID card with you, have it ready to tell the nurse your ID number.

Call 844-971-8907 (TTY: Dial 711)

When you call the Alliance Nurse Advice Line about your health questions, you will be entered into a monthly raffle. You could win a **$50 Target gift card!**

HEALTHY PEOPLE. HEALTHY COMMUNITIES.
www.ccah-alliance.org



Nurse Advice Line

Dial 844-971-8907 (TTY: Dial 711)

24 hours a day, 7 days a week.

The Alliance's Nurse Advice Line provides members with answers to health care questions 24 hours a day, seven days a week.

Please ensure that our members know that they can use the Nurse Advice Line for non-emergency questions when your office is closed, or if they are unable to reach you.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
1-800-700-3874

Member:
Member ID:
Birth Date:
Effective Date:
Program:
PCP:

Marker 1

Consejos de Enfermeras: 1-844-971-8907
Vision/Visión: Vision Service Plan (VSP) 1-800-438-4560
Dental/Cuidado dental: Denti-Cal 1-800-322-6384
TTY Line/Línea TTY: 1-877-548-0857
www.ccah-alliance.org

The phone number for the Nurse Advice Line is printed on the Alliance Member ID card.

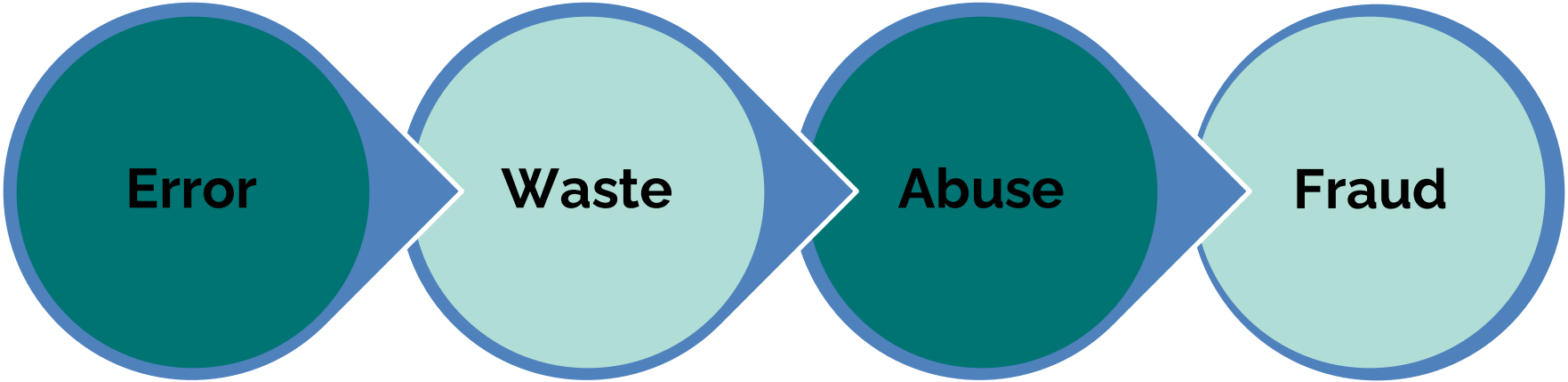
Link: https://thealliance.health/for-providers/manage-care/clinical-resources/nurse-advice-line/

Questions?

APPENDIX: FRAUD WASTE AND ABUSE COMPLIANCE

1. Laws Related to FWA
2. HIPAA Compliance
3. Reporting Concerns

Fraud, Waste and Abuse (FWA)



Mistakes
E.g. incorrect coding

Consumption of resources due to mismanagement, inappropriate actions, inadequate oversight; inefficiency. Typically, not a result of criminal actions.
E.g. Ordering excessive diagnostic tests

Activity inconsistent with sound fiscal, business, or medical practice resulting in unnecessary cost; bending the rules.
E.g. Improper billing practices

Intentional deception or misrepresentation made with the knowledge that deception could result in unauthorized benefit.
E.g. Billing for services not provided

Laws Relating to Fraud Waste and Abuse (FWA)

Laws to prevent engaging in fraudulent behavior and encouraging the reporting of FWA

Law / Requirement	Summary
Federal & California False Claims Act	• Prohibits the submission of fraudulent claims • Allows whistleblowers to be rewarded with a percentage of the money the government recovers
Anti-Kickback Statute	• Prohibits asking for / receiving anything of value in exchange for referrals of federal health care business
Physician Self-Referral Law	• Prohibits a physician from making referrals for certain designated health services to entities that they have a financial interest in
Medi-Cal Contract Requirements	• Requires health plans to report suspected FWA to the Department of Health Care Services

Link: Training materials available via Office of Inspector General Health Care Fraud Prevention & Enforcement Action Team

HIPAA Compliance

Providers are responsible for maintaining the confidentiality of Alliance member protected health information (PHI).

Law	Summary
Privacy Rule	• Ensures individuals' PHI is protected from unauthorized use/disclosure while allowing information flow needed to promote high quality care. • Includes: permitted / required disclosures, authorization to disclose information, patient right of access to records, etc.
Security Rule	• Establishes security standards for electronic PHI. • Includes: risk analysis, encryption, administrative / physical / technical safeguards to protect PHI
Breach Notification	• Requires Covered Entities to notify patients if their PHI has been breached; includes standards for determining if a breach occurred

Link: Training materials via the Office of Civil Rights

Reporting Compliance Concerns

Providers are our partners in ensuring compliance

Report HIPAA breaches and security incidents immediately, within the same business day that they're discovered

Report suspected FWA within 5 days of discovery

Reporting mechanisms:

Contact your Provider Services Representative

Email the Compliance Department: HIPAA@ccah-alliance.org

Complete form on Alliance Website

REQUIRED PROVIDER TRAININGS

1. EPSDT Training

Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (EPSDT)

- On an annual basis, all Network Providers must complete the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Training.
- Network Providers can access the training on the Alliance Provider Training webpage by clicking **Medi-Cal for Kids & Teens** under Resources.