



2023 Provider Manual



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This manual is revised periodically. For the most recent version, please visit the Alliance provider website at: <https://thealliance.health/for-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 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.

Merced County:

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

Monterey County:

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

Santa Cruz County:

Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

The Manual will be revised annually and/or periodically as needed. Providers will be notified when an updated

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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.thealliance.health

Provider Website: www.thealliance.health/for-providers

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 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’s health education and disease management programs and download health education materials.

[Cultural and Linguistic Services](#) — Learn about how to access the Alliance’s Language Assistance Services (Interpreter services) and cultural competency and health literacy tools.

Provider Portal: <https://thealliance.health/for-providers/provider-portal/>

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) can 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 Portal Representative will contact you to help you to set up an account.

Form Library: <https://thealliance.health/for-providers/resources/provider-forms/>

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 Mission, Vision and Values

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

Our Vision: Healthy people. Healthy communities.

Our Values:

Collaboration — Working together toward solutions and results.

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Equity — Eliminating disparity through inclusion and justice.

Improvement — Continuous pursuit of quality through learning and growth.

Integrity — Telling the truth and doing what we say we will do.

We achieve the goals set by our mission, vision 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 members representing physicians, clinics, hospitals, allied health providers, service agencies and the public.

Two groups provide advice to the Commission: The Physicians 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.

Full-Scope Medi-Cal

Alliance Medi-Cal beneficiaries are eligible for full-scope Medi-Cal, which provides coverage for the full range of Medi-Cal covered services. However, there are some full-scope aid codes that are under the fee-for-service Medi-Cal system, such as the Child Health and Disability Prevention (CHDP) Gateway aid codes and Share of Cost (SOC) 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. The Alliance provides coverage for the full range of Medi-Cal covered services for members with limited-scope aid-codes. Most other limited-scope aid-codes are under the fee-for-service Medi-Cal program.

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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.

Categories of Medi-Cal Eligibility: Aid Codes

Medi-Cal has more than 300 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.

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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 processed 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

Topic	Department/Contact	Phone #
Referral Forms		
Questions about Referral Forms	Health Services	800-700-3874, ext. 5506
Ordering Referral Forms	Provider Relations	800-700-3874, ext. 5504
Authorization Status	Health Services	800-700-3874, ext. 5511
Special Services		
Non-emergency Transportation	Access Coordinator All Counties	800-700-3874, ext. 5577
Interpreter Services	Health Programs All Counties	800-700-3874, ext. 5580
Case Management	Health Services All Counties	800-700-3874, ext. 5512

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Topic	Department/Contact	Phone #
Claims Inquiries (8:30 a.m. – 4:30 p.m.)	Claims	800-700-3874, ext. 5503
Contract Questions	Provider Relations	800-700-3874, ext. 5504
Eligibility for Medi-Cal	Social Services Santa Cruz County Monterey County Merced County	888-421-8080 877-410-8823 209-385-3000
Mild-Moderate Mental Health Services	Beacon Health Options	855-765-9700
Vision Service Plan	VSP	800-877-7195
Denti-Cal	State Office	800-322-6384
Denti-Cal Provider Services	State Office	800-423-0507
DME Issues	Health Services All Counties	800-700-3874, ext. 5506
Pharmacy	Health Services	800-700-3874, ext. 5507
Concerns about 1099's	CHANGE Healthcare/ECHO Health Inc.	888-983-5574
Health Education	Health Programs All Counties	800-700-3874, ext. 5580
Chief Medical Officer/ Medical Director	All Counties	800-700-3874, ext. 5588

Eligibility Assistance		
Member Services	Member Services	800-700-3874, ext. 5505
Automated Eligibility System		800-700-3874, ext. 5501
State Automated Eligibility Verification System (AEVS) Eligibility and SOC		800-456-2387
Inquiries about Members or Member Services		
Reassignment of Member (PCP Only)	Provider Relations	800-700-3874, ext. 5504
Request for Administrative Member Status Due to Medical Condition	All Counties	831-430-5512
Missed Appointment/No-show Calls	Provider Relations	800-700-3874, ext. 5504
Member Services Representatives (verification of eligibility and PCP linkage)	Member Services	800-700-3874, ext. 5505

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Provider Complaints and Grievances	Provider Relations	800-700-3874, ext. 5816
Recoveries or Other Insurance Recoveries	Finance	800-700-3874, ext. 5622
Behavioral Health		
Merced County <ul style="list-style-type: none"> Specialty Mental Health Services Substance Use Disorders 	County Mental Health Department	888-334-0163 209-381-6800
Monterey County <ul style="list-style-type: none"> Specialty Mental Health Services Substance Use Disorders 	County Mental Health Department	888-258-6029 831-755-5505
Santa Cruz County <ul style="list-style-type: none"> Specialty Mental Health Services Substance Use Disorders 	County Mental Health Department	800-952-2335 831-454-4170
Mental Health Services for Medi-Cal members, including CCS: <ul style="list-style-type: none"> Non-specialty Mental Health Services (formerly known as mild to moderate) autism spectrum disorders Behavioral Health Treatment Services for Development Disorders 	Beacon Health Options	855-765-9700
All Mental Health and Substance Use Disorder Services for IHSS	Beacon Health Options	800-808-5796

The Alliance Nurse Advice Line

Nurse Advice Line (NAL), available 24 hours a day, 7 days a week	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
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Section 2

Credentialing, Contracting and Compliance

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 new providers only).
- 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).
- New Provider Orientation Attestation (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.

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- 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).

Medi-Cal Certification is Required - Screening and Enrollment

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](#).

PCP Site Review

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.

New Provider Training

The new provider training materials will be included with the credentialing application for PCPs, Specialists, Allied or other providers, and providers will attest to completing the new provider training when completing the credentialing application. Providers are advised that training must be completed within 10 business days of their Active Status Date. For more information, please see Policy [300-6030 – New Provider Training](#).

Providers as HIV/AIDS Specialists

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 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.

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- 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 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 changes 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 does not provide any services to Alliance members. Additionally, any conduct that could adversely affect the health

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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 a provider right as 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](#) form 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 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

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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 program's 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.

Section 2. Credentialing, Contracting and Compliance

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 Chief 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.

Section 2. Credentialing, Contracting and Compliance

- 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:

1. Prompt and complete investigation of suspected/actual FWA. The SIU undertakes research and data analysis, internally and potentially externally, when necessary.
2. 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.
3. 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 emailing the following information to HIPAA@ccah-alliance.org.

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

Section 2. Credentialing, Contracting and Compliance

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

The provision of care within regulatory timely access standards will be assessed through a monitoring process, as described in relevant policies noted below. standards are described in Policy [404-1202 – After-Hours Availability of Plan and Contract Physician](#). Additional access standards and monitoring procedures can be found in Policy [401-1509 - Timely Access to Care](#) and Policy [300-8030 - Monitoring Network Compliance with Accessibility Standards](#).

Unlawful Harassment

Section 2. Credentialing, Contracting and Compliance

The 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:
 - Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's treatment.
 - Submission to or rejection of such conduct by an individual is used as the basis for decisions affecting the individual's welfare; or
 - 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, recalling, and identifying any clinical problems unique to your 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 site, as specified in Managed Care Quality and Monitoring Division (MCQMD) [Policy Letter 14-004](#). There are three components to the FSR process:

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

Section 3. The Role of the Primary Care Provider

- 2) The Medical Record Review survey (MMCD PL 14-004 Attachment B).
- 3) The Physical Accessibility Review survey (MMCD PL 14-004 Attachment C).

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 the 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. PCPs that do not meet CAP timelines, as specified in MMCD Policy Letter 14-004 timelines, are required to be removed from the network.

PCPs 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. Additionally, new members cannot be assigned to PCPs that score 79% or below in either Attachment A or B on a subsequent site review until the Alliance has verified that the PCP has corrected the deficiencies and the CAP is closed.

For more information on Facility Site Reviews, please see Policies [401-1508 - Facility Site Review Process](#) and 401-1521 – Physical Accessibility Review Survey.

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 Alliance [provider website](#).

Primary Care Provider Selection

Every new Alliance Medi-Cal member will be provided with 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.

Section 3. The Role of the Primary Care Provider

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 their 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 and diagnoses plan of care. For related instructions and information on the IHA codes please visit the CBI IHA Tip Sheet. Refer to MMCD Policy Letter 08-003 for requirements on IHA components. It is the providers' responsibility to code appropriately.

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. For more information on Adult Preventive Care, please see Policy [401-1502 - Adult Preventive Care](#).

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 the CDC recommended immunization schedule for adults and children, please visit the [CDC website](#). For more information on immunization services, please see policies [401-1505 - Childhood Preventive Care](#) and [401-1506 – Immunization Services and Reimbursement](#).

Providers should note that lead screening for children less than 6 years is a particular priority and state legal mandate. It is important that every encounter is coded with the correct CPT code, (83655 - Blood lead test)

Section 3. The Role of the Primary Care Provider

and submitted in a complete manner using the CMS 1500/UB 04 or 837 P/837 I to report confidential screening/billing to DHCS. Finally, providers are required to submit all blood lead screening test results to the Childhood Lead Poisoning Prevention Branch (CLPPB). State law also requires laboratories analyzing human blood drawn in California for lead to report all blood lead test results, on persons of any age, to the CLPPB. Analyzing laboratories must also report specific information on the person tested, the ordering physician, the analyzing laboratory, and the test performed. Information must be reported electronically.

For more information on lead screening, see Policy [401-1505 - Childhood Preventive Care](#).

Adverse Childhood Experiences Screening

For more information on training and payment for Adverse Childhood Experiences Screening (ACES), see policy [300-4180 – Training and Payment for Adverse Childhood Experiences Screening](#)

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

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 and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services to all members under 21 years of age, including pregnant women, with screening to start at 11 years of age related to alcohol and drug misuse as recommended by the American Academy of Pediatrics (AAP), Bright Futures, and USPSTF Grade A and B recommendations). SABIRT 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. 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. These sessions may be combined into 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. For those members who respond affirmatively to pre-screening, the Alcohol Use Disorder Identification Test – Consumption (AUDIT-C), for drug misuse, DAST-10, or other validated alcohol or drug screening questionnaires should be administered, PCPs are required to offer alcohol or drug 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.

Santa Cruz County Behavioral Health Access	(800) 952-2335 or (831) 454-4170
Monterey County Behavioral Health Access	(888) 258-6029 or (831) 755-5505
Merced County Behavioral Health Access	(888) 334-0163 or (209) 381-6800

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](#).

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Enhanced Primary Care Pain Management Program

The Enhanced Primary Care Pain Management Program has been developed to increase access to pain management and substance use 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 as well as for members 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.

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Eligible Services

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

Initial Visit

1. History and physical exam;
2. Assessment of cause of pain, current treatment regimen and/or any co-occurring substance use disorder;
3. Development of a plan of care regarding MAT;
4. Communications and follow-up with the Alliance regarding the member's condition; and
5. Must be billable under CPT codes 99204 or 99205

Follow-Up Visits

1. MAT management;
2. Services vary in duration and content depending on circumstances; and
3. 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.

Section 3. The Role of the Primary Care Provider

Health Risk Assessments

All newly enrolled SPD members 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 low, medium/rising, and high-risk stratifications, and members in the medium/rising risk stratification will be Alliance Care Management Services for complex case management. (Members stratified as being high risk will be offered Enhanced Care Management services through community-based providers). Administering the HRA and coordinating follow-up care is not the responsibility of the PCP, but you will be notified when members are enrolled in 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's 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 [404-1528 - Adult Complex Case Management](#) and Policy [404-1530 – Pediatric Complex Case Management](#)

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Comprehensive Tobacco Cessation Services

PCPs are responsible for screening for smoking and tobacco use among patients of all ages, providing counseling, and making appropriate referrals. Smoking and tobacco cessation 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., 99202-99215), 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 [401-3109 - 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.

CPT CODE	DESCRIPTION
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Office Visit	New Patient
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99202	Expanded problem focus; 20 minutes
99203	Detailed history, low complexity; 30 minutes
99204	Comprehensive history and exam; moderate complexity; 45 minutes
99205	Comprehensive history and exam; high complexity; 60 minutes

Office Visit	Established Patient
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99211	Minimal problem; physician supervised services; 5 minutes
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99212	Problem focus history and exam; 10 minutes
99213	Expanded problem focus history and exam; 15 minutes
99214	Detailed history and exam, moderate complexity; 25 minutes
99215	Comprehensive history and exam; high complexity; 40 minutes

Prevention New Patient

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

Prevention Established Patient

99391	Established patient, infant, periodic reevaluation
99392	Early childhood, age 1 to 4 years old
99393	Late childhood, age 5 to 11 years old
99394	Adolescent, age 12 to 17 years old
99395	18 to 39 years
99396	40 to 64 years
99397	65 years and older

Other Evaluation and Management

99417	Prolonged Physician Service; Office or Outpatient setting; each additional 15 minutes
99354	Prolonged Physician Service; Office or Outpatient setting; first hour
99355	Prolonged Physician Service; Office or Outpatient setting; each additional 30 minutes

Emergency Room

99281	ER Level 1
99282	ER Level 2
99283	ER Level 3
99284	ER Level 4

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99285 ER Level 5

Minor Surgical Procedures

11900 Injection; intralesional up to 7 lesions
11901 More than 7 lesions
16000 Initial treatment for 1st degree burns
16020 Dressing and/or debridement of burns; small
16025 Dressing and/or debridement of burns; medium
16030 Dressing and/or debridement of burns; large
46600 Diagnostic Anoscopy
51701 Insertion of non-indwelling bladder catheter (e.g., straight catheterization for residual urine)
51703 Insertion of temporary indwelling bladder catheter, complicated (e.g., altered anatomy, fractured catheter/balloon)
54055 Electrodesiccation
69200 Clear outer ear canal
69210 Removal impacted cerumen

Injections

20550 Injection; single tendon sheath or ligament
20610 Arthrocentesis, aspiration or injection, major joint or bursa only

Collection/Handling Blood

36400 Venipuncture, age 3 or under
36405 Scalp vein
36410 Venipuncture, over age 3
36420 Venipuncture, under age 1
36425 Age 1 and over
99000 Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory

Vision and Hearing

92081 Visual field exam

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92551	Screening test, pure tone
92552	Pure tone audiometry
92553	Air and bone
92555	Speech audiometry
92556	Threshold and discrimination
92557	Basic comprehensive audiometry
92567	Tympanometry (impedance testing)

Allergy Immunotherapy

95115	Single injection
95117	Multiple use allergy injections
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

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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.

Capitation Payment

For providers who are paid on a capitation basis for Primary Care Physician Services subject to case management, capitation rates are outlined in the Primary Care Physician Services Agreement. Below is a table that links Medi-Cal aid code to the corresponding Medi-Cal Member Type referenced in the Primary Care Physician Services Agreement. Please note, the Medi-Cal Member Type categories are not equivalent to DHCS aid code categories.

Aid Code	Aid Code Name	Medi-Cal Member Type
01	Refugee Coverage	Public Assistance: Family\Child\Family
02	Refugee Coverage	Public Assistance: Family\Child\Family
03	Adoption	Medically Indigent: Child
04	Adoption	Medically Indigent: Child
06	Adoption	Public Assistance: Family\Child\Family
07	Extended Adoption	Medically Indigent: Child
08	Entrant Coverage	Public Assistance: Family\Child\Family
10	SSI -- Social Security	Public Assistance: Aged
13	LTC	Medically Needy: Aged
14	Aged, Medically Needy	Medically Needy: Aged

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16	Aged, Pickle Eligibles	Public Assistance: Aged
17	SOC - Aged, Medically Needy	Medically Needy: Aged
20	SSI -- Social Security	Public Assistance: Disabled
23	LTC	Medically Needy: Disabled
24	Disabled, Medically Needy	Medically Needy: Disabled
26	Disabled, Pickle Eligibles	Public Assistance: Disabled
27	SOC - Disabled, Medically Needy	Medically Needy: Disabled
30	Aid to Families	Public Assistance: Family\Child\Family
32	Aid to Families	Public Assistance: Family\Child\Family
33	Aid to Families	Public Assistance: Family\Child\Family
34	Aid to Families	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
35	Aid to Families	Public Assistance: Family\Child\Family
36	Aid to Disabled	Public Assistance: Aged
37	SOC - Aid to Families	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
38	Continued Eligibility	Public Assistance: Family\Child\Family
39	Continued Eligibility	Public Assistance: Family\Child\Family
40	Foster Care	Public Assistance: Family\Child\Family
42	Foster Care	Public Assistance: Family\Child\Family
43	Foster Care	Public Assistance: Family\Child\Family
45	Foster Care	Medically Indigent: Child
46	Aid to Families	Public Assistance: Family\Child\Family
47	Medically Needy	% Poverty
49	Foster Care	Public Assistance: Family\Child\Family
53	LTC - No Acute Care	Medically Needy: Disabled
54	Continued Eligibility	Public Assistance: Family\Child\Family
59	Continued Eligibility	Public Assistance: Family\Child\Family
60	SSI -- Social Security	Public Assistance: Disabled
63	LTC	Medically Needy: Disabled
64	Disabled, Medically Needy	Medically Needy: Disabled
66	Disabled, Pickle Eligibles	Public Assistance: Disabled
67	SOC - Disabled, Medically Needy	Medically Needy: Disabled
72	Aid to Child	% Poverty
81	Medically Indigent	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
82	Medically Indigent	Medically Indigent: Child

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83	SOC - Medically Indigent	Medically Indigent: Child
86	Medically Indigent	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
87	Medically Indigent	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0A	Refugee Coverage	Public Assistance: Family\Child\Family
0E	Medi-Cal Access Program (MCAP)	Public Assistance: Family\Child\Family
0N	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0P	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0R	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0T	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0U	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
0W	BCCTP	Medically Needy: Family\Breast and Cervical Cancer Treatment Program (BCCTP)\Special – Medically Indigent: Adult
1E	Aged, Continued Eligibility	Medically Needy: Aged
1H	Aged, Medically Needy	Medically Needy: Aged
2E	Disabled, Continued Eligibility	Medically Needy: Disabled
2H	Disabled, Medically Needy	Public Assistance: Disabled
2P	ARC Program	Public Assistance: Family\Child\Family
2R	ARC Program	Public Assistance: Family\Child\Family
2S	ARC Program	Public Assistance: Family\Child\Family
2T	ARC Program	Public Assistance: Family\Child\Family
2U	ARC Program	Public Assistance: Family\Child\Family
3A	Aid to Families	Public Assistance: Family\Child\Family
3C	Aid to Families	Public Assistance: Family\Child\Family
3E	Aid to Families	Public Assistance: Family\Child\Family
3F	Aid to Families	Public Assistance: Family\Child\Family
3G	Aid to Families	Public Assistance: Family\Child\Family
3H	Aid to Families	Public Assistance: Family\Child\Family
3L	Aid to Families	Public Assistance: Family\Child\Family

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3M	Aid to Families	Public Assistance: Family\Child\Family
3N	Aid to Families	Public Assistance: Family\Child\Family
3P	Aid to Families	Public Assistance: Family\Child\Family
3R	Aid to Families	Public Assistance: Family\Child\Family
3U	Aid to Families	Public Assistance: Family\Child\Family
3W	Aid to Families	Public Assistance: Family\Child\Family
4A	Adoption	Medically Indigent: Child
4F	Aid to Child	Public Assistance: Family\Child\Family
4G	Aid to Child	Public Assistance: Family\Child\Family
4H	Foster Care	Public Assistance: Family\Child\Family
4K	Foster Care	Medically Indigent: Child
4L	Foster Care	Public Assistance: Family\Child\Family
4M	Former Foster Care	Medically Indigent: Child
4N	Foster Care	Public Assistance: Family\Child\Family
4S	Former Foster Care	Public Assistance: Family\Child\Family
4T	Foster Care	Public Assistance: Family\Child\Family
4U	Former Foster Care	Public Assistance: Family\Child\Family
4W	Aid to Families	Public Assistance: Family\Child\Family
5C	HFP Transition	Public Assistance: Family\Child\Family
5D	HFP Transition	Public Assistance: Family\Child\Family
5K	Foster Care	Medically Indigent: Child
5L	Foster Care	Medically Indigent: Child
6A	Disabled, Adult/Child	Public Assistance: Disabled
6C	Disabled, Adult/Child	Public Assistance: Disabled
6E	Disabled, Continued Eligibility	Medically Needy: Disabled
6G	Working Disabled	Medically Needy: Disabled
6H	Disabled, Medically Needy	Medically Needy: Disabled
6J	Disabled, Medically Needy	Medically Needy: Disabled
6N	Disabled, Continued Eligibility	Medically Needy: Disabled
6P	Disabled, Continued Eligibility	Medically Needy: Disabled
6R	Disabled, Continued Eligibility	Medically Needy: Disabled
6V	Disabled, Medically Needy	Medically Needy: Disabled
6W	Disabled, Medically Needy	Medically Needy: Disabled
6X	Disabled, Medically Needy	Medically Indigent: Child
6Y	Disabled, Medically Needy	Medically Needy: Disabled
7A	Aid to Child	% Poverty
7J	Aid to Child	Medically Indigent: Child
7S	Express Enrollment, Adult	Public Assistance: Family\Child\Family
7U	Express Enrollment, Adult	Adult Expansion

Section 3. The Role of the Primary Care Provider

7W	Express Enrollment, Child	Public Assistance: Family\Child\Family
7X	HFP Transition	Public Assistance: Family\Child\Family
8P	Medically Needy	% Poverty
8R	Medically Needy	% Poverty
8U	ACA, Infant	Public Assistance: Family\Child\Family
E6	MAP, Infant	Public Assistance: Family\Child\Family
E7	MCAP, Infant	Public Assistance: Family\Child\Family
H1	HFP Transition	Public Assistance: Family\Child\Family
H2	HFP Transition	Public Assistance: Family\Child\Family
H3	HFP Transition	Public Assistance: Family\Child\Family
H4	HFP Transition	Public Assistance: Family\Child\Family
H5	HFP Transition	Public Assistance: Family\Child\Family
K1	Aid to Families	Public Assistance: Family\Child\Family
L1	LIHP Transition	Adult Expansion
L6	ACA, Disabled Adult	Adult Expansion
M1	ACA, Adult	Adult Expansion
M3	ACA, Adult	Public Assistance: Family\Child\Family
M5	ACA, Child	Public Assistance: Family\Child\Family
M7	ACA, Pregnant Women	Public Assistance: Family\Child\Family
P5	ACA, Child	Public Assistance: Family\Child\Family
P7	ACA, Child	Public Assistance: Family\Child\Family
P9	ACA, Infant	Public Assistance: Family\Child\Family
R1	Aid to Families	Public Assistance: Family\Child\Family
T1	ACA, OTLIC - Premium	Public Assistance: Family\Child\Family
T2	ACA, OTLIC - No Premium	Public Assistance: Family\Child\Family
T3	ACA, OTLIC - Premium	Public Assistance: Family\Child\Family
T4	ACA, OTLIC – No Premium	Public Assistance: Family\Child\Family
T5	ACA, OTLIC – No Premium	Public Assistance: Family\Child\Family

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

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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 ext. 5505 (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.

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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:

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 the 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 eligible members (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

Section 4. Enrollment and Eligibility

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 Forms section 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.

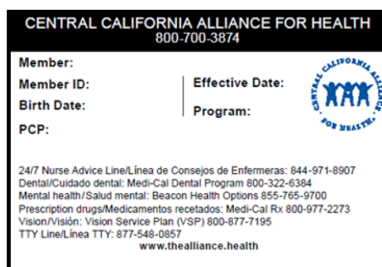
Claims for services rendered to administrative members must be sent to the Alliance. If the member has other health coverage, in addition to Medi-Cal, the claim should be sent first to the primary payer. All covered services that the Alliance is responsible for that are provided to administrative members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

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.

Section 4. Enrollment and Eligibility

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, this might 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.

Section 4. Enrollment and Eligibility

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 blue across the top and the Alliance logo on the top right-hand corner.





Section 5

Continuity of Care

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)

CBAS is an outpatient facility-based program that delivers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.

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.

Common services that CBAS centers offer to qualifying members are: professional nursing care, personal care services, social services, behavioral health services, speech therapy, therapeutic activities, and registered dietician-nutrition counseling.

Referrals for CBAS services may be made by a physician, community service agency, member, caregiver, 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 (or telephonically during PHE by Governor Health Order) 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

Section 6. Alliance Covered Benefits and Services

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.

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

The individual must meet the specific medical criteria of any one or more of the following categories:

Category 1: Nursing Facility-A (NF-A) level of care or above:

- Has been determined by DHCS to meet the NF-A level of care or above, and
- Meets eligibility and medical necessity criteria contained in Sections 14525(a), (c), (d) and (e); 14526.1(d)(1), (3), (4) and (5); and 14526(e) of the W&I Code (summarized in a. through e. below):
 - The individual is 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner or other health care provider has, within their scope of practice, requested CBAS services for the person.
 - The individual requires ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health or mental health professional to improve, stabilize, maintain or minimize deterioration of the medical, cognitive or mental health condition.
 - The individual requires CBAS services, as defined in W&I Code, Section 14550, that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the CBAS program to support the individual and their family or caregiver in the living arrangement of their choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing nursing or continuous nursing care.
 - Any individual who is a resident of an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) shall be eligible for CBAS services if that resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through CBAS, placement to a more costly institutional level of care would be likely to occur.

Except for individuals residing in an ICF/DD-H, the individual must meet all of the following:

- The individual has one or more chronic or post-acute medical, cognitive or mental health conditions that are identified by the individual's personal health care provider as requiring one or more of the following: monitoring, treatment or intervention, without which the individual's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization.

Section 6. Alliance Covered Benefits and Services

- The individual's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
- The individual lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
- The individual resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the individual.
- The individual has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the individual.
- A high potential exists for the deterioration of the individual's medical, cognitive or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization or other institutionalization if CBAS services are not provided.
- The individual's condition or conditions require CBAS services, on each day of attendance that are individualized and designed to maintain the ability of the individual to remain in the community and avoid emergency department visits, hospitalizations or other **institutionalization**.

Category 2: Organic, acquired or traumatic brain injury and/or chronic mental disorder:

- Has been diagnosed by a physician as having an organic, acquired or traumatic brain injury, and/or has a chronic mental disorder; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.; And
- Demonstrates a need for assistance or supervision with at least:
- Two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene; or
- One ADL/IADL listed above, and one of the following: money management, accessing resources, meal preparation, or transportation.

Category 3: Alzheimer's disease or other dementias:

- Individuals who have moderate to severe Alzheimer's disease or other dementia, characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease (see guide to stages below):
- Stage 5: Moderately severe cognitive decline. Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential.
- Stage 6: Severe cognitive decline. Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities.

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- Stage 7: Very severe cognitive decline. This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.

Category 4: Mild cognitive impairment including Alzheimer's disease or other dementias:

- Individuals have mild cognitive impairment including Alzheimer's disease or other dementias, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's disease, defined as mild or early-stage Alzheimer's disease, characterized by one or more of the following:
- Decreased knowledge of recent events
- Impaired ability to perform challenging mental arithmetic
- Decreased capacity to perform complex tasks
- Reduced memory of personal history
- The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.; AND
- The individual must demonstrate a need for assistance or supervision with two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

Category 5: Developmental disabilities:

- Meets the criteria for regional center eligibility; AND
- Meets CBAS eligibility and medical necessity criteria specified above in A.2.

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

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Community Health Worker (CHW) Benefit

Central California Alliance for Health (the Alliance) covers Community Health Worker Services to members that meet criteria in accordance with Alliance Policy and DHCS requirements. CHW care must be overseen by a Supervising Provider which must be a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization. Supervising Provider Responsibilities are as follows:

- Ensure that CHWs are approved through Alliance Peer Review and Credentialing.
- Oversee the CHWs and CHW Services delivered to members
- Appropriate claim submission of all CHW Services.
- Ensuring the provision of CHW services complies with all applicable requirements, and for providing direct or indirect oversight to CHWs.

Supervising Providers do not need to be physically present at the location when the CHW Services are provided to the members. Supervision of the CHWs as employees may be delegated as determined by the Supervising Provider.

Submission of a written recommendation by the supervising provider through the Alliance provider portal or by fax is required prior to the first 12 units of service. The recommended Provider must determine whether a member meets eligibility criteria for CHW services based on the presence of one or more of the following and verify the eligibility criteria on the referral form:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not been diagnosed.
 - Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
 - Any stressful life event presented via the Adverse Childhood Events screening.
 - Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
 - Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
 - One or more visits to a hospital emergency department (ED) within the previous six months.
 - One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months or being at risk of institutionalization.
 - One or more stays at a detox facility within the previous year.
 - Two or more missed medical appointments within the previous six months.

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- Member expressed need for support in health system navigation or resource coordination services.
- Need for recommended preventative services, including updated immunizations, annual dental visit, and well childcare visits for children.
- Violence prevention services

A member is not eligible for CHW services at the same time they are receiving services from ECM/CS. For members who need multiple ongoing CHW services, or continued CHW services after the first 12 units of services, a recommendation must be submitted to the Alliance initially and every 6 months that includes attestation that a written care plan is in place that has been updated annually.

A written care plan must be written by one or more individual licensed providers, which may include the recommending provider and other licensed providers affiliated with the CHW Supervising Provider. The provider ordering the plan of care does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services. CHWs may participate in the development of the plan of care, and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other Providers. The Plan of care may not exceed a period of one year. The plan of care must:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Include a list of other health care professionals providing treatment for the condition or barrier;
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

A licensed provider must review the member's plan of care at least every six months from the effective date of the initial plan of care. If there is a significant change in the recipient's condition, the plan may be amended.

For more information, please see policy [300-4035 - Community Health Workers Requirements](#)

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. Through eConsult, eligible primary care providers typically present a brief question regarding a patient's symptom management or diagnosis which may include medical records and images. Like email, communication occurs asynchronously, but includes follow up questions and clarifications.

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Program Eligibility

Requirements of Participating Providers

All participating providers must agree to vendors' terms of service and utilize eConsult services for Alliance 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 their 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 two vendors that offer eConsult services. 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 obtain eConsults with specialists.

Alliance approved eConsult vendors' information is listed below:

AristaMD

www.aristamd.com

Direct Dermatology

www.directderm.com

To become an eConsult referral 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 should:

- Provide urgent visits to non-linked Alliance members; and
- Be open for 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:

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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.

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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 physicians 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

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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](#)

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[Manuals](#). Providers should review the [Medi-Cal Provider Manuals](#) to confirm the code is allowed by Medi-Cal as a CLIA waived lab.

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.

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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 the 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).
- or
- 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, please see the [Long Term Care \(LTC\) Manual, Section: Admissions and Discharges](#) of the [Medi-Cal Provider Manuals](#).

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](#).

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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. 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

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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 provide 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

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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.

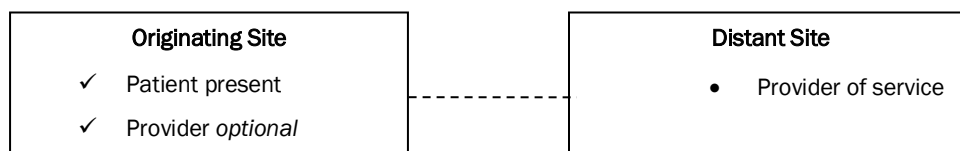
Billing Guidelines

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



Billing guidelines for originating site providers:

Originating Site	
Service	Code
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (if present)	E&M codes 99202 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.
Required Place of Service	Place of Service code "02" (not required for FQHCs, RHCs or HIS-MOA clinics)

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

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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:

Distant Site	
Service	Code
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Initial hospital care or subsequent hospital care (new or established patient)	99221 – 99233
Licensed Provider Fee	99202– 99215
Consultations: Office or other outpatient (Initial or follow-up), Inpatient, and confirmatory	99241 – 99255
E-Consultations	99451
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes
Required Place of Service	Place of Service code “02” (not required for FQHCs, RHCs or HIS-MOA clinics)

For IHSS members, the copay will be waived for services provided at the distant site.

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

Originating Site Patient present Provider <i>optional</i>	Information stored and forwarded to Distant Site	Distant Site Provider of service
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Billing guidelines for originating site providers:

Originating Site	
Service	Code
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (If present)	E&M codes 99202 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.
Required Place of Service	Place of Service code "02" (not required for FQHCs, RHCs or HIS-MOA clinics)

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 telehealth service 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:

Distant Store and Forward Site	
Service	CPT Codes
Licensed Provider Fee	92002, 92004, 92012, 92014, 99202-99215
Office consultation, new or established patient	99241 - 99255
E-Consultations	99451
Retinal photography with interpretation for services provided by optometrists or ophthalmologists	92250
Required Modifier	All asynchronous, store-and-forward services are billed with a "GQ" modifier

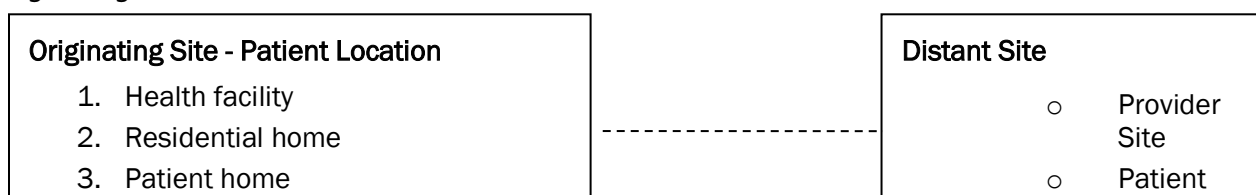
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Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)
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For lines of business that require a copay for services, the payment will be waived for services 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.



Billing guidelines for the distant site:

Distant Site	
Service	Code
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (if present)	E&M codes 99202– 99215
Required Modifier	95 modifier required for all CPT-Codes except Transmission Cost codes
Required Place of Service	Place of Service code "02" (not required for FQHC's, RHC's or HIS-MOA clinics)

For IHSS members, the copay 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, unless such exceptions have been granted under California or applicable Federal law or regulations.

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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.

Section 6. Alliance Covered Benefits and Services

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 applies 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.

Code	Description	Frequency Limitations
99202-99205	Office Or Other Outpatient Visit For The Evaluation And Management Of A New Patient	One time per 36 months per member
99212-99215	Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99241-99245	Office Consultation For A New Or Established Patient	One time per day per member
99304-99310	Initial Nursing Facility Care, Per Day, For The Evaluation And Management Of A Patient	One time per day per member
99324-99328	Domiciliary Or Rest Home Visit For The Evaluation And Management Of A New Patient	One time per day per member
99334-99337	Domiciliary Or Rest Home Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99341-99345	Home Visit For The Evaluation And Management Of A New Patient	One time per day per member
99347-99350	Home Visit For The Evaluation And Management Of An Established Patient	One time per day per member
99354	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	One time per day per member

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Code	Description	Frequency Limitations
99355	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	Four times per day per member
99356	Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; First Hour	One time per day per member
99357	Prolonged Service In The Inpatient Or Observation Setting, Requiring Unit/Floor Time Beyond The Usual Service; Each Additional 30 Minutes	Six times per day per member
99358-99359	Prolonged Evaluation And Management Service Before And/or After Direct Patient Care; First Hour	One time per day per member
99439	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 of death	One time per day per member
99487	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	One time per day per member
99489	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	One time per day per member
99490	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	No frequency limitation

Section 6. Alliance Covered Benefits and Services

Code	Description	Frequency Limitations
99497	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	One time per day up to two times per month per member
99498	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	One time per day up to two times per month per member
G0506	Comprehensive Assessment Of And Care Planning For Patients Requiring Chronic Care Management Services (List Separately In Addition To Primary Monthly Care Management Service)	One time per member at onset of chronic care management services

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.

Section 6. Alliance Covered Benefits and Services

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, or facility to home provided that the transport is medically necessary, has been requested by an Alliance provider, and has been authorized in advance by the Alliance. When possible, 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 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.5640.

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, and from a hospital or facility to the member's residence, provided that the transport is medically necessary.

Please contact the Transportation Coordinator at (800) 700-3874 ext.5640.

Section 6. Alliance Covered Benefits and Services

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.
- Members 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. Members should contact Alliance Member Services at **800-700-3874 (TTY: 800-735-2929 or 711) between 8 AM - 5:30 PM, Monday through Friday to request NMT.**

Section 6. Alliance Covered Benefits and Services

For more information on Non-Medical Transportation, please see [Policy 200-2010 Non-Medical Transportation](#)
For more information on the Meals, Transportation, and Lodging benefit for CCS-eligible members, please see [Policy 404-1732 Meals and Lodging \("Maintenance"\) 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." The following is a list of these benefits with contact information.

Dental Services

Please call Medi-Cal Dental program 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 for Medi-Cal members 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.

Santa Cruz County Behavioral Health Access	(800) 952-2335
Monterey County Behavioral Health Access	(888) 258-6029
Merced County Behavioral Health Access	(888) 334-0163

Substance Use Disorder (SUD) Services

Program Services

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. Services include Voluntary Inpatient Detoxification and outpatient opioid detoxification. The phone numbers for the County Behavioral Health

Section 7. Carved Out and Subcontracted Benefits and Services

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.**

- PCPs are required to provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) to members ages 11 years and older, including pregnant women.
- In the event that treatment slots are not available in the county alcohol and SUD treatment program within the Alliance's service area, the PCP can make a referral to the Alliance's Case Management team to assist in pursuing placement outside the area.
- Appropriate referrals for additional evaluation and treatment, including medications for addiction treatment, must be offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or SUD. Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services. Brief interventions must include the following:
 - Providing feedback to the patient regarding screening and assessment results.
 - Discussing negative consequences that have occurred and the overall severity of the problem.
 - Supporting the patient in making behavioral changes; and
 - Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

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 405-1111 – Community Based Adult Services](#) and [Policy 405-1108 - Medi-Cal Home and Community Based Services \(HCBS\) Waiver Programs](#).

Section 7. Carved Out and Subcontracted Benefits and Services

Prenatal Lab Tests:

Fetal aneuploidy screening with cell free DNA and alfa-fetoprotein are covered through the CDPH California Prenatal Screening Program.

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, or non-specialty mental health service 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 non-specialty (mild to moderate) mental health issues or specialty 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's Call Center at (855) 765-9700 24 hours a day, 365 days a year. Beacon's Call Center staff will assess the member's needs and provide contact information for contracted Beacon Behavioral Health Providers that can assist the member. 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.

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.

Section 7. Carved Out and Subcontracted Benefits and Services

- 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's Call Center staff will assess the member's needs and provide contact information for contracted Beacon Behavioral Health Providers that can assist the member. 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) means Medically Necessary, evidence-based behavioral interventions to promote, to the maximum extent practicable, the functioning of a member. These services are interventions designed to treat behavioral conditions as determined by a licensed physician, surgeon, or psychologist and it is a covered benefit for eligible Medi-Cal members. Prior authorization from the Managed Behavioral Health Organization, Beacon Health Options, is required. 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, as well as to provide medical follow-up for commonly co-occurring medical disorders. BHT services include applied behavioral analysis and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions. 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, 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.

Section 7. Carved Out and Subcontracted Benefits and Services

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 Care IHSS 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 Care IHSS member.

Section 7. Carved Out and Subcontracted Benefits and Services

Copayment

The copayment for behavioral health services 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 prefer to receive services via telehealth or 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

Section 7. Carved Out and Subcontracted Benefits and Services

- 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.

Section 7. Carved Out and Subcontracted Benefits and Services

- 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

Authorized Referrals

Authorized Referrals: Referral of an Alliance member to an Out of Service Area provider requires review and authorization by the Alliance prior to the services being rendered. Referral of an Alliance Care In-Home Support Services (IHSS) (Other Lines of Business) member to any non-contracted provider requires authorization by the Alliance. The Alliance reviews such referrals to ensure that medical criteria are met and that the member is referred to an appropriate provider, prior to providing Authorization for the referral. For more information on referrals to out of service area or non-contracted providers, please see [Policy 404-1310 - Authorization Process for Referrals to Out of Service Area Non-Contracted Specialty Providers](#).

Alliance Service Area: The Alliance's Medi-Cal Service Area consists of Santa Cruz, Monterey, and Merced counties. The Alliance's Service Area for In-Home Supportive Services (IHSS) is Monterey County

In Service Area Provider: Any provider based in the Alliance's Service Area, regardless of contract status.

Local Out of Service Area Provider: 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 payments, and the need for access to the provider's specialty type.

Out of Service Area Provider: A provider not based in the Alliance's Service area, regardless of contract status and not designated by the Alliance as a Local Out of Service Area Provider.

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-referred services described below under "Self-Referral."

PCPs should use an Authorized Referral form for any service provided by an out of area provider. Direct specialist to specialist referrals require submission of an Authorized Referral request by the referring specialist.

For authorization purposes, a requested service or medical equipment is approved if it 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](#).

Section 8. Referrals and Authorizations

Referral Consultation Requests (RCR)

Consultation Requests: Referral of an Alliance member by Primary Care Provider (PCP) or In-Network Specialist to a specialty physical health care provider within the Alliance Service Area or Local Out of Service Area.

Prior authorization is required for any service provided by a non-contracted, non-credentialed and/or out of area provider. For more information on the Referral Consultation Request (RCR) process, please see policy 404-1303 - Referral Consultation Request Process.

PCPs should submit a Referral Consultation Request (RCR) form when referring members for specialty medical care to a provider within the Alliance's service area.

Direct referrals from specialist to occupational and physical therapy providers require submission of a Referral Consultation Request (RCR) form by the referring specialist.

For WCM CCS-eligible members, an authorization is required for all Specialist referrals.

Referral Consultation Requests (RCR) and Authorized Referrals are not required for administrative members. For more information on Administrative status, please see Policy [200-5000 – Administrative Member Status](#) and Policy [404-1201 Authorization Request Process](#).

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 from PCPs in the following situations:

- Emergency care
- Sensitive Services
- Office visits related to Gender Dysphoria and/or Gender Affirming Care (GAC).
- Post Emergency Department (ED) follow up care for the treatment types referenced below.

When member is seen in the Emergency Department (ED), a referral is not needed for follow-up care with a specialist for treatment types listed below:

- Orthopedic surgeons: for documented or suspected fracture, sprains, and strains
- General surgeons: For chronic cholecystitis
- Ophthalmologists: For emergency retinal detachment; corneal abrasions; burns and retained foreign bodies; acute ocular infections; and glaucoma emergencies
- Pain management: For acute or acute onset chronic lumbar and/or cervical radiculopathy

Section 8. Referrals and Authorizations

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, as follows:

- 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 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.
- 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.
- Office visits related to gender dysphoria and/or gender affirming care.

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 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.

For after-hours authorization of post-stabilization requests for non-contracted facilities, the provider should contact The Alliance Medical Director on-call at 831-429-7484. For more information, please see Alliance [Policy 404-1202 After-Hours Availability of Plan or Contract Physician](#).

Section 8. Referrals and Authorizations

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 are necessary to make informed choices and understand contraceptive methods.
- High-risk sexual behavior.
- Laboratory tests, if medically indicated as part of the decision-making process for choice of contraceptive methods.
- Limited history and physical examination.
- Observation following alleged rape or seduction.
- Pthirus 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 401-3104 Disease Management Programs](#)

[Policy 300-4080 Open Access to Care](#)

Section 8. Referrals and Authorizations

Referral Guidelines

The PCP and/or other referring physician is 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. Specialists need the medical information on the referral to be as specific as possible. Care should be taken by the PCP in completing authorized referral requests since what is authorized will determine the scope and duration of services and claims paid for these services.

The referral specialist is responsible for informing 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.

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).
- Specialty consultation/treatment.

Section 8. Referrals and Authorizations

Serious and Complex Medical Conditions

Providers should develop a written treatment plan for members with serious and complex 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 – Standing and Extended Referral Authorizations](#)

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.

Audiology, Podiatry, Occupational and Speech Therapy

The Alliance provides coverage for Audiology, Podiatry and Speech Therapy services, with referral requirements as noted below.

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.

Out-of-Service-Area Referrals

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

If there is no contracted provider available within the service area, 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.

Section 8. Referrals and Authorizations

The Alliance must review and approve referrals to out-of-service-area providers before the service can be provided. This is called an Authorized Referral. The process for these referrals is for the PCP to complete and submit an Authorization Request form to the Alliance

Members with a CCS-eligible condition must always be referred to a CCS paneled provider for their CCS-eligible condition. These requests must be authorized by the Alliance.

In the event of an urgent/emergent medical situation outside of the Alliance service area, the facility providing the service is required to contact the Alliance 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](#).

Open Access to Care

It is the policy of the Alliance to allow and encourage Medi-Cal members to seek care from Network Providers. Referrals to specialty care for Medi-Cal members are approved without prior authorization for in service area Contracted and Credentialed Providers.

Prior authorization may be required for any service provided by a non-contracted, non-credentialed in-area provider, and is required for out of area providers.

A Medi-Cal member may seek care without referral for sensitive services from any provider who is enrolled in the Medi-Cal Program, regardless of their contracted status with the Alliance. Members may receive emergency services from any provider regardless of their contract status with the Alliance or Medi-Cal enrollment status. For more information, please see [Policy 300-4080 – Open Access to Care](#).

Prior Authorizations

Authorization requests 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.

ARs Authorizations 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 authorizations. Only the Alliance Chief Medical Officer, Medical Directors or Pharmacists have the authority to modify or deny authorization requests. Authorization decisions are based upon evidence-based Alliance policies as well as nationally recognized standards including:

Section 8. Referrals and Authorizations

- Title 22 criteria
- Medi-Cal Medical Necessity Guidelines (when available)
- California Children’s Services (CCS) Medical Necessity Guidelines (when available)
Alliance Health Services & Pharmacy Guidelines and Policies & Procedures approved by the Continuous Quality Improvement Committee and the Pharmacy and Therapeutics Committee.
- Evidence-based guidelines, such as:
 - MCG (formerly Milliman Care Guidelines)
 - Medicare (CMS) Guidelines
 - Consensus statements and nationally recognized standards of practice.
- Guidelines developed by other health plans.
- Expert opinion:
 - Clinical advisors serving on Alliance Committees
 - 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:

1. Allergy treatment, please see Policy [404-1734 – Immunotherapy Authorization](#)).
2. Genetic Testing, please see Policy [404-1715 - Genetic Testing](#))
3. Home Health services.
4. MRIs and unlisted CT scans.
5. Physical, occupational and speech therapy.
6. Podiatric treatment. Prior authorization for podiatric services rendered by podiatrists is not required if a physician or surgeon rendering the same services would not be required to request prior authorization
7. Outpatient surgery.
8. Non-emergency hospitalizations, except for an obstetrical delivery.
9. Some medical supplies and Durable Medical Equipment (DME).
10. Requests for referral to an out-of-service-area provider/facility or a non-contracted provider/facility.
11. Non-Emergency Medical Transportation
12. Palliative Care Outpatient Services
13. Sleep studies, please see Policy [404-1711 — Sleep Study \(Polysomnography/Sleep Disorder Testing\) Authorizations](#))
14. Sclerotherapy procedure, please see Policy [404-1203 — Surgical Treatment of Varicose Veins](#))
15. Electromyography, Nerve Conduction Studies, please see Policy [404-1713 —Electromyography, Nerve Conduction Studies](#))
16. Physician-Administered Drugs and drugs 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).
17. Total Joint Replacement Surgery

Section 8. Referrals and Authorizations

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

Some medical supplies and DME require prior authorization. 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 authorization request 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.

Section 8. Referrals and Authorizations

Submitting Prior Authorization Requests

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

- The Alliance Provider Portal.
- Fax to (831) 430-5850.
- 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 ensure the timeliest decision:

1. Please complete the form — an illegible handwritten form may be returned to the provider.
2. Be sure to include your name, address and contact number — and fax number.
3. Be sure to include member's name, address, age, sex, date of birth, and identifying information such as the member's Alliance ID Number.
4. The Medi-Cal identification number must be correct. Refer to the Medi-Cal card if necessary.
5. 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.
6. Use the correct ten-digit provider identification (NPI) number. If the patient is hospitalized, the hospital NPI must be used.
7. Attach documentation that supports the medical necessity of the request to the form (in addition to providing documentation required in the Medical Justification box).
8. Be sure to sign and date the form (must be signed by the referring provider).
9. 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 submit a prior Authorization Request before services are provided. For routine pre-service requests for procedures/services that can be pre-scheduled without danger of adverse outcome to the member, the Alliance strives to make a determination *within 5 business days, but no longer than 14 days* from receipt of the request and appropriate documentation of medical necessity.

Section 8. Referrals and Authorizations

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 Authorization Request 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 when 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 72-hours 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. The Alliance 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 from the date on which the member obtained eligibility.

For more information about the authorization review process, please see Policy [404-1201 - Authorization Request Process](#).

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.

Section 8. Referrals and Authorizations

- 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 Authorization Requests for completeness and will help you with any aspect of the process, including answering questions regarding the status of the authorization. Please call (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.

Section 8. Referrals and Authorizations

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

Status	Comments
Approved as Requested	You may provide service as requested. Please remember to include the Authorization# on your claim.
Approved as Modified	<p>Most Common Reasons for Approved as Modified:</p> <ul style="list-style-type: none"> • Fewer visits are authorized than were requested on the Authorization Request. • Number of inpatient days requested on the Authorization Request is not within the guidelines on length of stay for the requested procedure. • Dates of service requested on the Authorization Request do not match the dates that the member is Alliance eligible.
Extended / Deferred	<p>Most Common Reasons for Extended / Deferred Authorization Request:</p> <ul style="list-style-type: none"> • Authorization Request 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. • Insufficient medical information supplied on or with the Authorization Request to enable appropriate medical decision. • Necessary equipment pricing catalog pages not submitted.
Denied	<p>Common Reasons for a Denial:</p> <ul style="list-style-type: none"> • Request is for dental care services, which are Medi-Cal services authorized and reimbursed by an agency <i>other than the Alliance</i>. • 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. <p>A denial letter will be sent to the member, explaining the denial and information about rights to appeal the decision.</p> <p>If you need clarification of the reason your Authorization Request was denied, please call the Alliance's Authorization Coordinator at (800) 700-3874 ext.5506.</p>

For more details, see Policy [404-1109 - Disclosure of Utilization Management Process to Providers, Members and the Public](#).

Section 8. Referrals and Authorizations

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](#)

Policy [404-1702 - Provision of Family Planning Services to Members](#)

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 at Fax number (831) 430-5850. 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 after-hours authorization of post-stabilization requests by non-contracted facilities, the provider should contact The Alliance at (831) 423-5560. For more information, please see Alliance Policy [404-1202 After Hours Availability of Plan or Contract Physician](#).

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

Section 8. Referrals and Authorizations

Referral Guidelines		
Service	Linked members who are assigned to a Primary Care Physician.	Un-linked or administrative members who do not have a PCP assignment.
Referral / specialty consultation (non – CCS) – in-area	Prior Approval and authorization are not required for contracted and credentialed providers. PCP completes “ Referral / Consultation ” form and submits to the Alliance.	Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.
Referral / specialty consultation (CCS) – in-area	Prior authorization approval may be required for noncontracted, non credentialed providers. PCP or specialist complete “Authorization Request” form and submit to Alliance for review.	PCP or specialist complete “Authorization Request” form and submit to Alliance for review.
Referral / specialty consultation – out-of-area providers	Prior authorization approval is required. PCP or specialist complete “Authorization Request” form and submits to Alliance for review. This applicable to both out of area and non-contracted, non-credentialed providers.	Member may self-refer. Provider must accept Medi-Cal and bill the Alliance.
Referral / Enhanced Care Management (ECM) Services	Prior authorization approval is required for services PCP, ECM Provider, Member or any Member Related Support person may refer. Provider must be a contracted ECM provider and accept Medi-Cal and bill the Alliance.	Prior authorization approval is required for services Member, Providers, or member related may refer. Provider must be a contracted ECM provider and accept Medi-Cal and bill the Alliance.
Allergy Treatment	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.	Member may self-refer for an initial evaluation. Provider must accept Medi-Cal and bill the Alliance. Additional treatment requires an authorization.

Section 8. Referrals and Authorizations

Referral Guidelines		
Service	Linked members who are assigned to a Primary Care Physician.	Un-linked or administrative members who do not have a PCP assignment.
Physical therapy	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.	For those members who are Administrative Members, or non-PCP linked, a provider prescription is required for an initial evaluation and treatment.
Podiatry, Speech, Occupational Therapy	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.	
Chiropractic	Medi-Cal 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.	
Acupuncture	Medi-Cal 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.	
Family planning and sensitive services	Member can self-refer to any provider that is a Medi-Cal provider.	
OB care	Member can self-refer to any in-area Medi-Cal obstetrical provider.	
Authorization required for:		
DME, medical supplies, prosthetics and orthotics	Purchase: individual item over \$250.00 Rental: over \$100/month Repair or Maintenance: over \$500 Incontinence supplies: over \$330	
Hospital care	Any elective admission including surgical procedures All transplants	
Imaging procedures	MRI PET scans Unlisted ultrasound, nuclear medicine and CT	

Section 8. Referrals and Authorizations

Referral Guidelines		
Service	Linked members who are assigned to a Primary Care Physician.	Un-linked or administrative members who do not have a PCP assignment.
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	
Enhanced Care Management (ECM) Services	Requires authorization. The Alliance will guarantee payment for the initial outreach while the ECM Provider completes the needs assessment, associated assessments, and member consent. The following months require authorization, usually approved in 6 mos. Intervals.	

Section 8. Referrals and Authorizations

Referral Guidelines		
Service	Linked members who are assigned to a Primary Care Physician.	Un-linked or administrative members who do not have a PCP assignment.
Community Supports (CS)	Housing Deposit (once per lifetime, unless additional documentation is obtained to demonstrate the member would be more successful on the second attempt) Housing Tenancy and Sustaining Services Housing Transition Navigation Service Medically Tailored Meals (post auth for post acute stay- Recuperative Care (post auth) Short Term Post Hospitalization Housing (post auth) Sobering Center (post auth) Environmental Accessibility Accommodations/Home Modifications (\$7,500 per lifetime, unless the member's place of residence changes or if the member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.	
Other	Hearing aids Non-emergency medical transportation – any medical transportation request requires prior authorization	



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 be denied 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

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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.

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 from CMS electronically for professional services only currently. The Alliance may not receive the crossover claim electronically if all service lines were denied by Medicare, or if the service was billed on the UB claim form. In these instances, providers would be required to submit the hard copy claim to the Alliance. For all other situations, 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. If you believe that your secondary claim was processed incorrectly, please contact our Claims Department at (800) 700-3874 ext.5503. Providers submitting crossover claims must still comply with Medi-Cal's timeliness guidelines as well as follow up timely on any claim issues or denials. For crossover claims,

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timeliness is based on the Medicare RA date; for example, to receive 100% of reimbursement the crossover claim would need to be received within 6 months of the Medicare RA Date.

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's information as well as the primary payer's 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:

1. A copy of the Remittance Advice or Identification of Overpayment notification from the Alliance indicating the date overpayment was requested or recouped.
2. 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.

\$32.00	Medi-Cal Allowed
\$53.90	Medicare Paid
\$ 0.00	Medi-Cal Reimbursement

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 A

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Provider's Charge	\$250.00
Medicare Allows	200.00
Medicare Pays (80% of Medicare allowed amount of \$200.00)	160.00
Medi-Cal Allowable	<u>180.00</u>
Difference	20.00
Share of Cost Collected	<u>25.00</u>
Medi-Cal would pay	\$ 0.00

Example B

Provider's Charge	\$250.00
Medicare Allows	200.00
Medicare Pays (80% of Medicare allowed amount of \$200.00)	160.00
Medi-Cal Allowable	<u>190.00</u>
Difference	30.00
Share of Cost Collected	<u>25.00</u>
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.

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- 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.

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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 the 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

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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

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, 8:30 AM – 4:30 PM.

Office hours for the Claims Department phones are Monday – Friday, 8:30AM – 4:30PM, 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:

1. 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).
2. Date of service.
3. Dollar amount billed.
4. Date the claim was sent to Alliance.
5. Provider NPI/TIN

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

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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.

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.

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).

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Claim Forms Used by Different Types of Providers

Applies to	Type of Claim Form	Type of Provider	Service(s) Billed on This Form
Medi-Cal, Alliance Care IHSS	CMS	PCPs Specialists Clinics Pharmacies Laboratories Allied health practitioners	All professional services 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.
Medi-Cal, Alliance Care IHSS	UB-04	Hospitals/Clinics Laboratories	All professional or facility services. SNF levels of care services when billed by approved facilities for Medi-Cal members.
Medi-Cal, Alliance Care IHSS	25-1C	LTC	All LTC services billed with accommodation codes.
Medi-Cal, Alliance Care IHSS	30-1	Pharmacies	Non-compound drug prescriptions.
Medi-Cal, Alliance Care IHSS	30-4	Pharmacies	Compound drug prescriptions
Medi-Cal, NEMT, NMT	CMS or Invoice* CMS/UB/EDI/ Clearing house	ECM/CS Providers Non-Emergent Transportation Providers	ECM and CS Services NEMT, NMT

*If an ECM/CS Provider lacks the technical capabilities to submit compliant claims, they may bill for services by invoice. Providers should reach out to a Claims Customer Service Representative for guidance on setting up invoice billing. Invoices will be entered in a spreadsheet provided by the Alliance and uploaded through a secure site. Similar to claims submission, all invoices will be required to contain specific data elements as outlined by DHCS CalAIM ECM /CST Billing and Invoicing Guidance.

Adherence to the following checklist for effective submission of claims will ensure timely payment:

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1. 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.
2. Bill on 8-1/2 x 11 paper (including attachments).
3. Be sure to include the patient's full name, without abbreviating.
4. 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*.
5. Include Authorization Numbers (Box #63 on the UB or Box 23 on the CMS): Type all AR and referral numbers on the claim.
6. 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.
7. 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"). Do not add decimals.
8. For newborn services using mom's ID see the following claim form completion instructions in the [Medi-Cal Provider Manuals](#):
9. CMS Completion (cms comp)
10. UB-04 Completion: Outpatient Services (ub comp op)
11. 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 field (Box 59).
12. 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.
13. 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.

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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 them 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 99202-99215 or 99241-99245.

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.

- **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.
- **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.

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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. When billing for these services, please use the following codes:

Cardiac Rehabilitation – Referral Required: 93797, 93798

Cardiac Rehabilitation – Prior Authorization Required: G0442, G0423

Pulmonary Rehabilitation – Referral Required: 94625, 94626

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 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](#)

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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.

Community Health Worker and Asthma Preventive Services are Medi-Cal Benefits

Effective for dates of service on or after July 1, 2022, Community Health Worker (CHW) services and Asthma Preventive Services (APS) are now benefits for the Medi-Cal program for the following codes:

Code	Description
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients
T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs

For specific information relative to each of these codes and how they apply to CHW or APS services, refer to

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the *Asthma Preventive Services (APS)* and *Community Health Worker (CHW) Preventive Services* sections in the Part 2 Provider Manual. Rates information for these codes can be found on the [Medi-Cal Rates](#) webpage.

Community Supports (CS) Housing Deposits

Housing Deposits are a one-time benefit for services or modifications necessary to enable the Member to establish a basic household. Members must also be receiving Housing Transition/Navigation services to qualify for this benefit. Prior authorization is required, and Providers must submit an itemized housing support plan indicating the associated costs with the authorization request. The total payment per member is not to exceed \$5,000

Use the following information when billing for Housing Deposits:

HCPCS:	Modifier:	Description:	Billing:
H0044	U2 U2, GQ	Housing Deposits	Bill once within the 6-month authorized period for the amount noted in the housing support plan. Providers must document in the description field of the claim form or invoice the county of residence and the number of bedrooms.

DME Travel

The Alliance will pay for mileage at \$.32 per mile for a wheelchair vendor to go and repair a member's chair. It would also cover for the vendor to pick up and bring the chair back to their shop for repair. It would be paid under E1399 with remarks added to the claim X2999.

This benefit is limited to only Alliance eligible members. Alliance members with Medicare and other health insurance coverage would not be eligible. This benefit was effective 1/1/99.

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](#)

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[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, 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.

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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:

93000	93005	93010	93015
93016	93017	93018	93024
93025	93040	93041	93042
93224	93226	93227	93228
93229	93268	93270	93271
93303	93304	93306	93307
93308	93312	93315	93318
93320	93321	93325	93350
93880			

Enhanced Care Management (ECM) Outreach

An ECM “outreach attempt” is defined as an in-person or telephonic/electronic attempt to connect with an individual member for the purpose of explaining and extending ECM services to members that have been identified as meeting ECM eligibility requirements and have an approved authorization by the Alliance as being eligible to receive ECM.

ECM outreach payments are a one-time payment to the ECM Provider who has been assigned to the member. Outreach payment will be made to ECM Provider regardless of whether member agrees to receive ECM services or not, as long as there is documentation of adequate outreach attempts.

ECM Providers shall conduct outreach primarily through in-person interaction where members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Providers may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the member’s consent.

ECM Providers shall use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to reflect a member’s stated contact preferences:

- Mail
- Email
- Texts

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- Telephone calls
- Telehealth

In developing the ECM benefit and optional CS services, DHCS estimates that 60% of member's outreached are reachable, and 60% of reachable members will need repeat outreach attempts. DHCS also assumes that outreach engagement will require approximately two hours per member, on average.

Providers are required to document their ECM Outreach attempts. The Alliance collects this information through claims data while Providers must maintain their own records of outreach attempts.

The required data to be tracked for all outreach efforts:

Data Element:	Documentation:
Member Number	Entered on the claim form or invoice
Provider Type	Entered in the "Description" field of the claim or invoice
Date of Outreach Attempt	Entered as the DOS on the claim or invoice
Outreach Attempt Method	The procedure code/modifier combination on the claim or invoice

Use the following HCPCS codes and modifiers when billing for ECM Outreach services:

HCPCS:	Modifier:	Description:	Billing:
G9008	U8	ECM Outreach in Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified. ECM Outreach	Bill in 15-minute increments. 1 unit= 15 minutes
	U8, GQ	Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	
G9012	U8	ECM Outreach in Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	Bill in 15-minute increments. 1 unit= 15 minutes
	U8, GQ	ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is a federally mandated telephone and computer-based application program that electronically verifies in-home service visits. As a result, this program will aid in reducing fraud, waste, and

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abuse. The EVV program must verify each type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

Effective 1/1/2023, EVV is required for all Medi-Cal Home Health Care Services (HHCS) and Personal Care Services (PCS) that are delivered during in-home visits by a provider, including PCS. These may include, but are not limited to, HHCS and PCS delivered as part of Community-Based Adult Services. PCS consist of services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

The State of California contracted with Sandata Technologies, LLC (Sandata) to provide a state sponsored EVV system. Sandata is providing California with an EVV system that includes the ability to capture data elements during the visit, data portals that allow providers to view and report on visit activity, and an EVV Aggregator to provide California with EVV program oversight and analytics.

Exclusions

The following services are not subject to EVV requirements:

- HHCS or PCS that do not require an in-home visit are not subject to EVV requirements.
- HHCS or PCS provided in congregate residential settings where 24-hour service is available are not subject to the EVV requirements.
- HHCS or PCS rendered by an individual living in the member's residence does not constitute an "in-home visit" and is not subject to EVV requirements.
- Any services rendered through the Program of All-Inclusive Care for the Elderly.
- HHCS or PCS that are provided to inpatients or residents of a hospital, nursing facility including skilled nursing facility or residence of nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases.
- Durable Medical Equipment is not subject to EVV requirements.

Requirements

All applicable HHCS and PCS providers must complete the self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator, including providers of Community Supports – Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs. Once registered, Network Providers and Subcontractors will gain access to extensive training and technical assistance, including self-guided learning modules and EVV system demonstrations, provided by Sandata. Self-registration, resources, and additional training are available at <https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx>.

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All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:

- 1) The type of service performed;
- 2) The individual receiving the service;
- 3) The date of the service;
- 4) The location of service delivery;
- 5) The individual providing the service; and
- 6) The time the service begins and ends.

All claims for PCS and HHCS services must be submitted with allowable Current Procedural Terminology or Healthcare Common Procedure Coding System codes as outlined in the Medi-Cal Provider Manual. MCPs and/or providers must also indicate the proper Place of Service Code or Revenue Code on claims and/or encounters to indicate the rendering of PCS or HHCS in a member's home.

All Network Providers are required to comply with the EVV requirements when rendering PCS and HHCS, subject to federal EVV requirements. The Alliance monitors and ensures compliance with these requirements, and alerts DHCS to any compliance issues, as below:

- Monitors providers for compliance with the EVV requirements and CalEVV Information Notice(s), and alert DHCS to any compliance issues;
- Supplies providers with technical assistance and training on EVV compliance;
- Requires providers to comply with an approved corrective action plan; and
- Denies payment if the provider is not complying with EVV requirements and arrange for the participants to receive services from a provider who does comply.

When a Network Provider is identified as non-compliant with these requirements, the Alliance will not authorize the Network Provider to perform services and/or will withhold the payment.

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.

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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 E1399 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.
- E1399 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.

*Travel repair wheelchairs/Scooter should be added to remarks

Wheelchair Replacement Rentals

When the member's wheelchair needs to be repaired and will take multiple days, the Alliance will pay claims as a daily rental when claims are submitted per the following guidelines:

- Providers must bill with code E1399 which requires authorization
- Providers are required to bill their units as the number of days that the wheelchair was needed
- The base code for the member's existing wheelchair must be entered in box 19.
 - For example, "member owns a K0823."
- The Alliance will pay these as a daily rental using the monthly rental rate divided by 30 for the daily rate.

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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](#)

[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 \(Urgent Care\) Billing Location Expansion](#)

[600-1048 - Manual Pricing of a Service When There is No Medi-Cal Rate](#)

[600-1050 – Implementation of Medi-Cal Rates](#)

[600-1072 – AB 72](#)

[600-2201-Reimbursement for Non-Emergency Medical Transportation \(NEMT\)](#)

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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).

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

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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)

Occupational Therapy Codes (if CPT criteria met)		Speech Therapy Codes (if CPT criteria met)	
X4100 Medi-Cal claims only	Evaluation – initial 30 minutes, plus report	92507 Medi-Cal and Commercial claims	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
X4102 Medi-Cal claims only	Evaluation – each additional 15 minutes, plus report	92508 Medi-Cal and Commercial claims	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
X4110 Medi-Cal claims only	Occupational Therapy - Treatment - Initial 30 Minutes		<i>Facilitated Communication:</i> There are no specific codes for facilitated communication
X4112 Medi-Cal claims only	Occupational Therapy - Treatment - Each Additional 15 Minutes		<i>Altered Auditory Feedback Devices:</i> There are no specific codes for altered auditory feedback devices
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		
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		

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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.

Physical Therapy Codes for Medi-Cal Lines of Business (if CPT criteria met)			
99243	An initial Physical Therapy Evaluation – requires a referral from the member’s linked Primary Care Physician (PCP) or treating physician.	97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion and flexibility.	97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97014	Application of a modality to 1 or more areas: electrical stimulation therapy		
97112	Neuromuscular reeducation (97112) of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	97530	Therapeutic activities direct (one on one) patient contact by provider, each 15 minutes.
97113	Aquatic therapy with therapeutic exercises	97535	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
97116	Gait Training includes stair climbing		

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.

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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:

- E1399: Simple wheelchair evaluation Code X2995 in remarks
- E1399: Complex wheelchair evaluation code X2997 should be added to the remarks

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

Information about Electronic Data Interchange (EDI) Transactions

About EDI

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

The 837 transaction is used to submit medical claims for payment or submission of encounter data used to satisfy regulatory reporting requirements. For additional details on transaction instructions, and the Alliance's business and processing rules relevant to the implementation of 837 transactions, reference the Alliance's [EDI Companion Guide](#).

If you are interested in submitting electronic claims either directly to the Alliance or through an established clearing house, please complete, **sign** and return the EDI Claims Enrollment form to edisupport@ccah-alliance.org. Or simply complete the online EDI form. Please contact the EDI Support Team for more information at edisupport@ccah-alliance.org.

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Benefits

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

1. Ability to submit 24/7
2. Immediate verification of claims received
3. Decreased data entry errors > Faster payment.
4. Reduced paper claim costs > No paper claims to print.
5. Lower print costs > No ribbon or toner expense.
6. Reduced mailing costs > No envelopes or stamps to buy.
7. Decreased office costs > No overhead to print, sort, stuff and mail claims.
8. 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](#).

Clearinghouses

If you do not have the ability to submit EDI claims directly to the Alliance, we have partnered with many established Clearinghouses.

The two most commonly clearinghouses used are:

[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)

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

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Support

The Alliance EDI Unit can be reached directly at edisupport@ccah-alliance.org.

Change Healthcare and ECHO Health, Inc. for all Fee-For-Service (FFS) and capitation payments

The Alliance collaborates with third party vendors, Change Healthcare (CHC) and ECHO Health, Inc., to assist with payment processes. Providers receive payments directly from ECHO for Fee-For-Service (FFS) and capitation payments.

Providers who are eligible for CBI (Care-Based Incentive) payments will continue to receive funds via paper check issued directly from the Alliance by mail or in-person delivery.

ECHO consolidates individual provider and vendor payments into a single ERISA and HIPAA compliant format, remits electronic payments and supplies an explanation of provider payment details to providers.

There are three types of payment options available through ECHO:

- Virtual Credit Card (VCC)
- Electronic Funds Transfer (EFT)
- Paper Checks

To enroll and receive 835 files from your desired clearinghouse for ECHO payments, complete one of the following options:

- ECHO can supply the hard copy ANSI 835 Enrollment Form

or

- You may access: <https://enrollments.echohealthinc.com> and select the option to enroll in an ERA only.

[Read the FAQ guide for details.](#)

If you have additional questions regarding your payment options, please contact ECHO Health at 888-984-0804.

For assistance with any technical support issues, contact ECHO Health customer service at 888-834-3511.

Frequently Asked Questions about Claims

- 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.

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- How do I interpret information on the Alliance Remittance Advice (RA)?

Please refer to the Alliance Remittance Advice Guide available on our [provider website](#).

- 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.

- 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, 8:30 AM - 4:30 PM at (800) 700-3874 ext. 5503, choose Option 1.

- 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

- 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.

- How does the Alliance process claims for children eligible for California Children's Services (CCS)?

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-](#)

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[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.

- 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.

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- How are refunds or reversals/takebacks 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.

- 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, 8:30 a.m. - 4:30 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.

- When can I bill an Alliance member for 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:

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- 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.

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.

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- 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 or decimals
- All information added to claim forms must be properly aligned to fit within the appropriate box. Information that is not aligned correctly within a box may cause a claim to be denied.

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.
- Electronic submission: 837I Loop 2300, Segment DTP with qualifier 434.
- **CMS-1500 Hardcopy, Field 18: Hospitalization Dates Related to Current Services**
 - 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 these dates.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
	MM		DD		YY		MM		DD		YY
FROM	FROM			DOS			TO	TO			DOS

- **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.

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- 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)
- Electronic submission: 837I Loop 2300, Segment DTP with qualifier 435.

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR
		08/01/19	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.

31 CODE	32 CODE	33 CODE	34 CODE	35 CODE	36 CODE
11	08/01/19				

- 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.



Section 11

Care Management Services

Continuum of Health Care Management

The Alliance Care Management (CM) team works with members and PCPs/providers to provide basic population health management (BPHM) services and supports to improve and/or maintain health and quality of life. All members receive BPHM regardless of their current health and social status. For members identified as having medium/risk or high-risk health/social needs, complex care management or ECM/CS services may be offered. 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** optimal 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, including Community Supports

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, member, and member support system. 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

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- Linkage to community and social support resources
- Creation of mutually agreed upon care plans, including targeted interventions
- 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):

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

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

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

For additional information about Complex Case Management, please see the following policies:

Policy [404-1528 – Adult Complex Case Management](#)

Policy [404-1530 Pediatric Complex Case Management](#) Case Management

Basic Population Health Management (BHPM)

BPHM includes access to primary care, care coordination, navigation and referrals across health and social services, information sharing, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and prevention programs, chronic disease programs, programs focused on improving maternal

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health outcomes, and case management services for children under EPSDT 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 BPHM system to function:

1. Members receiving basic case management must be assigned to a PCP.
2. 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.
3. 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.
4. The objectives of BPHM 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](#).

Transitional Care Coordination

Transitional Care Coordination is defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports, post-acute care facilities, or long-term care (LTC) settings. Care Coordination involves the deliberate organization of patient care activities and sharing of information among all the providers who are working with members to achieve

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safer and more effective care across all settings and delivery systems. The following elements are included in Transitional Care Coordination:

- Coordination of Admissions, Discharges, and Transfers
- Plan support with Prior Authorizations and Timely Discharges
- Alliance Communication of Assignment of the Care Manager to member and providers
- Coordinating and verifying that members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations.
- Support with Discharge Planning and follow up
- Referrals and coordination with community resources and services, including other Case Management programs, Local Education Agencies, Regional Centers, etc.

Common support that the Care Coordination Team assist members with are:

- 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
- Assessments of members requesting Community Based Adult Services (CBAS)

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 Complex 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 [404-1314 Children with Special Health Care Needs \(CSHCN\)](#)

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 members 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.

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

SARC Santa Cruz Field Office	SARC Monterey Field Office	CVRC Merced Field Office
1110 Main Street Watsonville, CA 95076 Tel. (831) 900-3737 Fax (831) 498-9844	1370 South Main Street Salinas, CA 93901 Tel. (831) 900-3636 Fax (831) 424-3007	3172 M Street Merced, CA 95348 Tel. (209) 723-4245 Fax (209) 723-2442

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 404-1316 Early Intervention Services](#)

[Policy 404-1314 Children with Special Health Care Needs](#)

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 SARC, CVRC, Santa Cruz County Health Services Agency, Monterey County Health Services Department, and Merced County Department of Public Health. An MOU is an agreement that delineates how 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.

Enhanced Care Management and Community Supports

Enhanced Care Management

As of January of 2022, the Alliance began offering Enhanced Care Management (ECM) services consistent with Medi-Cal benefit guidelines.

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Alliance members through systematic coordination of services and

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comprehensive, community-based care management. ECM is part of a broader population health system design within CalAIM.

ECM is one of the components of the state's CalAIM efforts. CalAIM is a multi-year initiative led by the Department of Health Care Services (DHCS) that aims to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing delivery system and payment reforms across the program. CalAIM leverages Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents and takes a person-centered approach that targets social determinants of health and reduces health disparities and inequities.

Target Populations Eligible to Receive ECM: ECM will be provided initially to three populations of focus:

- Individuals and families that are experiencing homelessness AND have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.
- High Utilizing Adults: Adults with 5 or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence; And/or 3 or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
- Adults with Serious Mental Illness and/or Substance Use Disorders: Adults who meet the eligibility criteria for participation in or obtaining services through:
The County Specialty Mental Health (SMH) System; AND/OR
The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program;
AND
Are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of ACEs, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors); AND
Meet one or more of the following criteria:
 - High risk for institutionalization, overdose and/or suicide;
 - Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care;
 - Two or more ED visits OR two hospitalizations due to SMI or SUD in the past 12 months;
 - Pregnant and post-partum women (12 months from delivery).
- Adults Living in the Community who Are at Risk for LTC Institutionalization
 - Adults living in the community who meet the Skilled Nursing Facility (SNF) Level of Care criteria;
 - OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;
 - AND are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the

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- need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring),
 - AND (3) are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).
- Nursing Facility Residents Transitioning to the Community
 - Nursing facility residents who are:
- Interested in moving out of the institution;
- Are likely candidates to do so successfully; and
- Able to reside continuously in the community

Eligibility will be expanded to additional populations in accordance with Medi-Cal guidelines.

ECM Core Services: ECM contracted Providers will offer the following services to qualifying members:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning
- Enhanced Coordination of Care
- Health Promotion Activities
- Comprehensive Transitional Care Planning
- Member and Family Supports
- Coordination of and Referral to Community and Support Services

Making a Referral for ECM

Referrals for ECM may be made by a physician, the member or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Services provider. The referral can be made by using the [Enhanced Care Management Provider Referral Form](#).

ECM Authorizations

Authorization through the Alliance is required for members to obtain ECM services. Alliance staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to the Alliance to determine eligibility. The authorization process entails eligibility screening, member consent to receive ECM services, a comprehensive community assessment of the member by the ECM Provider, completion of a Member Care Plan by the ECM Provider, and decision-making by the Alliance. If approved after the Alliance assessment, the members may receive ECM services. Reauthorization is required every six months by submitting an Authorization Request to the Utilization Management Department, along with necessary documentation for review. Documentation for the reauthorization may be submitted through the care coordination platform.

ECM Encounter Requirements

ECM Providers are required to provide ECM services to each of their assigned Members at least once per month. ECM Providers are also required to provide the Alliance with encounter data within 30 days of the

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encounter occurring to ensure that the Alliance can comply with DHCS requirements for oversight of the ECM benefit.

For more information regarding ECM Encounter Submission requirements, see policy [300-4175-Enhanced Care Management Encounter Data](#).

Discontinuing ECM Services

The ECM Provider will notify the Alliance to discontinue ECM for members when any of the following circumstances are met:

- The member has met all care plan goals;
- The member is ready to transition to a lower level of care;
- The member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
- The ECM Provider has not been able to connect with the Member after multiple attempts.

If the member is discontinued from ECM during a current authorization period, the ECM provider will submit a PCR. For more information on ECM, please see [Policy 405-1308 - ECM Overview](#) and [Policy 405-1309 - ECM Core Services](#).

Community Supports

Community Supports are medically appropriate and cost-effective alternative services. Federal regulation allows states to offer Community Supports as an option for Medicaid managed care organizations, and the Alliance has elected to offer some Community Support services.

Community Supports are optional services for the Alliance to offer and are optional for members to receive. As of January 1, 2023, the Alliance offers the following Community Supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Medically Tailored Meals
- Sobering Center (Merced and Monterey County only)
- Recuperative Care
- Short Term Post Hospitalization Housing
- Environmental Accessibility Adaptations/Home Modifications

Community Supports are designed to help avert or substitute hospital or nursing facility admissions, discharge delays, and emergency department use when provided to eligible members. Community Supports will typically be provided by community-based organizations and providers. ECM Providers may also serve as Community Supports Providers, if they have appropriate experience.

Members Eligible to Receive Community Supports

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The Alliance must determine eligibility for a pre-approved Community Supports using the DHCS Community Supports definitions, which contain specific eligibility criteria for each Community Supports. The Alliance is also expected to determine that a Community Supports is a medically appropriate and cost-effective alternative to a Medi-Cal Covered Service. When making such determinations, the Alliance must apply a consistent methodology to all members within a particular county and cannot limit the Community Supports only to individuals who previously were enrolled in the WPC Pilot. Some Community Supports are once in a lifetime, or have specific funding caps.

Making a Referral for Community Supports

Referrals for Community Supports may be made by a physician, an Alliance member or their caregiver, community service agency, hospital or health care provider, or an ECM or Community Supports provider. The [Community Supports Provider Referral](#) form can be found on the Alliance website.

Community Supports Authorizations

Authorization through the Alliance is required for members to obtain Community Supports. Alliance staff will utilize the information received on the referral, as well as other data sources (including social determinants of health data) available to determine eligibility. The authorization process entails eligibility screening, completion of a Member Care Plan by the ECM Provider (if receiving ECM services), and decision-making by the Alliance. If approved after the Alliance assessment, the member may receive Community Supports. Some Community Supports, such as housing deposits, are limited to once per lifetime. Utilization management procedures will consider the goals of each Community Supports and the Alliance will not categorically deny or discontinue a Community Supports irrespective of member outcomes or circumstance. Community supports requests that are inherently time-sensitive will be accepted and reviewed by the Alliance as post service requests to avoid delays or disruptions in member services, examples of Community Supports that will be processed post service include, but are not limited to, Sobering Center, Recuperative Care, and Medically Tailored Meals post-acute care, as outlined in policy [404-1201 - Authorization request process](#).

Some Community Supports will require periodic reauthorization by submitting an Authorization Request to the Utilization Management Department, along with any necessary documentation for review. Documentation for the reauthorization may be submitted through the ECM/Community Supports care coordination platform or [Provider Portal](#).

For more information on Community Supports, please see Policy [405-1310-Community Supports Overview](#) and Policy [300-4185-Community Supports Encounter Data](#)

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 motivational interviewing and trauma inform care 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.

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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 or visit our [provider website](#).



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. The Alliance has implemented the Healthier Living Program; is an evidence-based self-management program originally developed at Stanford University. It's 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. Workshops are conducted on-site at local and convenient locations in the community, virtually, or telephonically. 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

Section 12. Disease Management Program

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 can receive a gift card up to \$50. 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. Members can be referred by their PCP or other Alliance case management staff, or members 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. TARs are not required for the basic program, as outlined below; however, TARs 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 (DPE)

Members of any age diagnosed with pre-diabetes can participate in diabetes prevention education for up to four (4) hours of individual training and up to 16.5 hours of group training during the initial twelve-month period, and up to two (2) hours of either individual or group training annually thereafter. 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 hours of DPP sessions for the first 12 months of the DPP benefit (Core Sessions and/or Core Maintenance Sessions) per the full CDC curriculum and a second year comprised of eight (8) hour sessions (ongoing maintenance sessions) to promote maintenance, which is reserved for those individuals who have successfully completed the first year and have achieved and maintained their weight

loss goal. These services are provided through Alliance-approved DPP education providers who can bill for these services. Members can be referred by their PCP or other Alliance case management staff or can self-refer. 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. 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.

DPP education providers who are interested in joining the Alliance network must adhere to the following requirements prior to contracting with the Alliance:

- DPP education providers must comply with guidelines issued by the CDC DPRP and obtain pending, preliminary, or full recognition by the CDC. As a CDC-recognized organization, DPP providers are required to use the National DPP CDC-approved lifestyle change curriculum.
- DPP education providers who are CDC-recognized organizations must also be Medi-Cal enrolled providers and comply with Medi-Cal program integrity rules such as confidentiality, screening, and disclosure standards in order to become a Medi-Cal DPP Supplier. This applies to both currently enrolled and newly enrolled providers; DPP suppliers must have DHCS approval prior to rendering DPP services to Medi-Cal members. Please visit the [DHCS website](#) for important information, including required Medi-Cal program components.
- DPP education providers must hold a National Provider Identifier (NPI), cannot be debarred, and must maintain at least one administrative location in California. An “administrative location” is defined as the physical location associated with the DPP’s operations, and where DPP services may or may not be furnished.
- DPP education can be delivered by non-medical personnel such as peer coaches, lifestyle coaches, community outreach workers, and/or promoters. The DPP may be delivered through an online, virtual, or in-person format.
- DPP education providers must be contracted with the Alliance and abide by all requirements outlined in DHCS APL 18-018 and Alliance policies related to provider credentialing guidelines.

For additional information about the Alliance’s credentialing policies and procedures, please visit the [credentialing policies](#) link on the Alliance [provider website](#). For information about the Alliance DPP, please see the following policy and resources:

[401-3105 Diabetes Prevention Program and Diabetes Self-Management Education Benefit](#)

[Alliance Diabetes Prevention Program \(DPP\) Benefit Description](#)

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.

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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:

- 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.
- 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.
- 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. These 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.
- 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 Program

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.5580** for more information.

Health Education Programs

Participating members also 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.

Weight Management Education

Healthy Weight for Life: Adolescent Weight Management: An Alliance program designed to engage with members ages 2-18 who are identified as high-risk. High-risk members 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 will be invited to participate in a series of workshops modeled after the National Triple P program. The Triple P program is a comprehensive, evidence-based, multi-level-parenting program designed as a specific strategy of intensive family intervention for families with an overweight or obese child.

Workshops cover 15 hours of materials and four telephone support calls over a 10-week period.

Workshops are conducted on-site at local and convenient locations in the community or virtually. Workshops focus on promoting children's physical health, managing childhood obesity, and strengthening families by:

- promoting positive relationships
- helping parents promote healthy social-emotional development in their children
- teaching parents simple and effective strategies for handling everyday parenting challenges

Alliance members who participate in the weekly sessions can receive a gift card up to \$100. In addition, participants are entered in a raffle to win a bike.

There is no cost for Alliance members to participate. Workshops are conducted in English and in Spanish. Members can be referred by their PCP or other Alliance case management staff, or members 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.

Section 13. Health Education Program

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 18 years of age or older to be considered.

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 HMHB 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 800-300-8086, "Kick It California", 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. 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](#).

Section 13. Health Education Program

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 samples of health education materials at no cost 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 at no cost 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 (QPIP) Goals

The goal and objective of the QPIP is objectively and systematically monitor and evaluate, pursue opportunities to improve, and resolve identified problems related to the:

- Quality and safety of healthcare and services provided by the Alliance's provider network:
 - Incorporate provider and other appropriate professional involvement in the QPIP through review of findings, study outcomes, and on-going feedback for program activities
 - Conduct facility site reviews/medical record reviews at provider sites and reviewing quality issues or trends referred for further investigation and follow-up actions
 - Develop and maintain a high-quality provider network through credentialing, re-credentialing, and peer review processes
 - Maintain an ongoing oversight process by incorporating performance metrics of QPIP-related functions performed by practitioners, providers, and delegated or independently contracted/sub-contracted delegates
 - Ensure that care and resources are available, appropriate, accessible, and timely for all members according to standards of care and evidence-based practices
 - Monitor and act upon over/underutilization of services
- Quality of services provided by the Alliance to its members, providers, the community, and internal staff:
 - Align quality improvement activities with activities that promote the continuous development of a provider network that meets member needs, such as the annual Access Plan
 - Implement innovative practices, such as telephonic or virtual means, to ensure that members obtain care which is timely and meets their needs
 - Utilize data-driven approaches and effective analysis, implementation, and evaluation towards improved clinical outcomes, services, and experiences

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- Ensure care is provided regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and linguistically appropriate manner
 - Identify population-based strategies to address healthcare disparities in order to develop appropriate interventions and tools including cultural and linguistic (C&L) competency, communication, and education
 - Provide access to services and communication in alternate formats to ensure non-discrimination of members as defined in Section 1557 of the Patient Protection and Affordable Care Act
 - Education regarding accessing the health care system and support on obtaining care and services when needed
 - Concerns resolved quickly and effectively including the right to voice complaints or concerns without fear of discrimination
 - Engagement in the discussion about services, regardless of cost or benefit coverage
 - Confidence that they can reach the Alliance quickly and be satisfied with the information received.
- Members' experience of care and service provided by the Alliance and its contracted providers:
 - Monitor member satisfaction with quality of care and services received from network providers, practitioners and delegates and acting upon identified opportunities
 - Obtain information on member's values, needs, preferences, and health-related goals through feedback mechanisms and touch points, such as surveys, focus groups, member outreach, care management, and other means
 - Establish population health programs to empower and encourage members to actively participate in and take responsibility for their own health through the provision of health education, evidence-based tools, and shared goals for optimal health
 - Create a trusted health care system to assure feelings of safety, self-efficacy, and effective communication with all their care partners
 - Develop and implement activities for members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services for availability, accessibility, clinical services, and care management
 - Integrate with current community health priorities, standards, and public health goals

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- Implement activities to monitor and act upon continuity and coordination of care improvements between medical and behavioral health specialties and within the medical care system

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 [401-1305](#)) and work plans [the Quality Improvement Work Plan (QIWP) and Utilization Management Work Plan (UMWP)]. Once approved, the CQIC 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 two 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 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
- Getting Care Quickly
- Healthplan Customer Service
- How Well Doctors Communicate
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Care

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

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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' (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) quality measures. The audit assesses how well the Alliance network is providing services to our members, while ensuring accurate and reliable measurement.

HEDIS Measurement Year (MY) 2022

The Alliance's Quality Improvement Population Health Department is preparing for the upcoming season by reviewing current rates and possible target areas for improvement. This is accomplished by evaluating Administrative Data consisting of claims, pharmacy, immunization registry, provider submitted data and other supplemental data.

Hybrid/Administrative measures are subject to medical record review. If these measures are not identified as compliant through administrative data, the Alliance may request specific medical records from clinics to establish additional measure compliance.

The DHCS MCAS for Measurement Year 2022 (MY 2022) includes a total of 39 measures. The Alliance is held to the NCQA 50th Percentile benchmark for 15 of these measures. Should the Alliance fall beneath the benchmark in any measures, it may be subject to economic sanctions and corrective action plans.

Please see below the comprehensive list of MY 2022 MCAS measures.

Measure Acronym	Performance Measure	Measure Type Methodology	Held To MPL
BCS	Breast Cancer Screening	Administrative	Yes
CCS	Cervical Cancer Screening	Hybrid/Administrative	Yes
WCV	Child and Adolescent Well-Care Visits	Administrative	Yes
CIS-10	Childhood Immunization Status—Combination 10	Hybrid/Administrative	Yes
CHL	Chlamydia Screening in Women	Administrative	Yes
FUM 30 Day	Follow-Up After ED Visit for Mental Illness – 30 days	Administrative	Yes
FUA 30 Day	Follow-Up After ED Visit for Substance Abuse – 30 days	Administrative	Yes

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HBD	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control (> 9%)	Hybrid/Administrative	Yes
CBP	Controlling High Blood Pressure	Hybrid/Administrative	Yes
IMA–2	Immunizations for Adolescents—Combination 2	Hybrid/Administrative	Yes
LSC	Lead Screening in Children	Hybrid/Administrative	Yes
PPC–Post	Postpartum Care	Hybrid/Administrative	Yes
PPC–Pre	Timeliness of Prenatal Care	Hybrid/Administrative	Yes
W30-6+	Well-Child Visits in the First 30 Months of Life - 0 -15 Months - Six or More Well-Child Visits	Administrative	Yes
W30–2+	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	Administrative	Yes
AMB–ED	Ambulatory Care—Emergency Department (ED) Visits	Administrative	No
AMM–Acute	Acute Phase Treatment	Administrative	No
AMM–Cont.	Continuation Phase Treatment	Administrative	No
AMR	Asthma Medication Ratio	Administrative	No
AAP	Adults' Access to Preventive/Ambulatory Health Services	Administrative	No
COL	Colorectal Cancer Screening	Hybrid/Administrative	No
CCW-MMEC	Contraceptive Care--All Women: Most or Moderately Effective Contraception - 60 Days	Administrative	No
CCP-MMEC60	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	Administrative	No
TFL-CH	Topical Fluoride for Children	Administrative	No

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DRR-E	Depression Remission or Response for Adolescents and Adults	ECDS	No
DEV	Developmental Screening in the First Three Years of Life	Administrative	No
SSD	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications	Administrative	No
FUM	Follow-Up After ED Visit for Mental Illness – 7 days	Administrative	No
FUA	Follow-Up After ED Visit for Substance Use – 7 days	Administrative	No
ADD-C&M	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	Administrative	No
ADD-Init	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	Administrative	No
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Administrative	No
NTSV CB	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	Administrative	No
POD	Pharmacotherapy for Opioid Use Disorder	Administrative	No
PCR	Plan All-Cause Readmissions	Administrative	No
PDS-E	Postpartum Depression Screening and Follow Up*	ECDS	No
PND-E	Prenatal Depression Screening and Follow Up*	ECDS	No
PRS-E	Prenatal Immunization Status	ECDS	No

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DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	ECDS	No
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Please visit the [HEDIS Website](#) of the Alliance provider website for additional information on MY 2022 MCAS 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:

1. Providing appropriate care within the designated time frames defined by NCQA or CMS;
2. Clearly documenting all care provided in the patient's medical record;
3. Accurately coding all claims (see MY 2022 MCAS Code Set on the [HEDIS Website](#));
4. Responding promptly and accurately to medical records requests (within five to seven business days of request); and
5. 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 as accurately reporting 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 when providing the QI team and the Alliance's HEDIS vendor EHR access that PHI is maintained in accordance with federal and state laws. For more information about HEDIS, please see Policy [401-1607 Healthcare Effectiveness Data and Information Set \(HEDIS\) Program Management and Oversight](#).

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:

1. External quality review using the MCAS measure calculation to evaluate the quality of care provided to our members and for comparison against national or regional benchmarks.
2. Site reviews of PCP facilities for criteria such as: patient safety, physical accessibility, infection control and quality of medical records.

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3. Disease surveillance and reporting public health authorities, as applicable.
4. Provider contracting, credentialing and recredentialing processes, including peer review activities.
5. Timely access monitoring to ensure the provision of covered services in a timely manner.
6. Member satisfaction monitoring including analysis of member satisfaction surveys, complaints and appeals.
7. Provider satisfaction surveys.
8. Medical and pharmaceutical claim/encounter data analysis to identify sentinel events, variations in practice and potential fraud, waste and/or abuse.
9. 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.
10. Population needs assessment to evaluate the health education and cultural and linguistic needs of members.
11. 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.
12. Stratified data studies to evaluate population(s) as needed.
13. Development and annual review of the QIWP and UMWP.
14. 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:

1. Listings of members who need specific services;
2. Listings of members who need intervention based on pharmacy indicators;
3. Comparison of practitioner/provider performance to average plan-wide performance;
4. Reports showing practitioner/provider deviation from a benchmark or threshold;
5. Recommended interventions to improve performance;
6. Barrier analyses and intervention plans/timelines;
7. Plan-sponsored training directed at improving performance;
8. Incentives for improved or above average performance in quality of care or service;

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9. 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](#)

[401-1501 - Standards of Care](#)

[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 and Linguistics 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 language assistance at no cost 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 communication assistance at no cost 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 interpreter services at no cost, 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.

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- A minimum of 10 business days for all standard Non-ASL requests (e.g., foreign language).
- 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

1. Due to the complex and sensitive nature of medical care, it is not appropriate to use unqualified bilingual persons as interpreters.
2. The Alliance strongly discourages the use of unqualified interpreters, including bilingual office staff or patients' friends or family members, especially minors.
3. 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.
4. Providers must not require patients to bring their own interpreters or suggest that they use a friend or family member to interpret.
5. Providers are required to document the offer of and patient acceptance or refusal of interpreter services in the medical record.
6. 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

Outpatient Pharmacy Services

Medi-Cal

Effective January 1, 2022, all pharmacy services billed as a pharmacy claim transitioned from the Alliance pharmacy benefit to Medi-Cal Rx, a Medi-Cal Fee-For-Service (FFS) program, including:

- Outpatient drugs (prescription and over the counter)
- Physician-Administered Drugs (PADs)
- Enteral nutritional products
- Medical supplies.

Medi-Cal Rx does not include pharmacy services billed as a medical (professional) or institutional claim. For Physician-Administered Drugs billed as a medical claim, see "Physician-Administered Drugs" below.

Members must obtain their prescribed drugs from a pharmacy that is in Medi-Cal Rx pharmacy network. List of pharmacies is available on the Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov or by calling Medi-Cal Rx Contractor, Magellan Medicaid Administration, Inc., at 800-977-2273.

Medi-Cal Rx Contract Drugs List and Prior Authorization Requests

The list of covered drugs for Medi-Cal Rx, or Contract Drugs List (CDL), is available on the Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov. Certain pharmacy drugs and medical supplies may require prior authorization (PA). Prior authorization requests must be submitted to Medi-Cal Rx via the methods listed below. Medi-Cal Rx PA Request Form and additional information are available on Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov or by calling Medi-Cal Rx at 800-977-2273.

- Medi-Cal Rx Provider Portal www.Medi-CalRx.dhcs.ca.gov
- CoverMyMeds® (CMM) www.covermymeds.com
- Fax 800-869-4325
- United States (US) Mail
Medi-Cal Rx Customer Service Center
ATTN: Provider PA Requests
P.O. Box 730
Rancho Cordova, CA 95741-0730
- NCPDP P4 – Request Only

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Emergency Dispensing of 72-Hour Supply

Dispensing of a 72-hour emergency supply of any medication for which delaying the dispensing would withhold a medically necessary service is permitted by Medi-Cal Rx without requirement for a prior authorization. For more information, please refer to Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov or call Medi-Cal Rx at 800-977-2273.

Alliance Care IHSS

The Alliance has partnered with MedImpact, a Pharmacy Benefit Manager (PBM) to process pharmacy claims and prior authorization requests for Alliance Care IHSS members. Members must take their prescriptions to a pharmacy in MedImpact's network. To find a pharmacy, search in [MedImpact's Pharmacy Directory](#). For more information regarding the Alliance Pharmaceutical Services Access, please see Policy [403-1126 – Pharmaceutical Services Access](#).

Drug Formulary and Prior Authorization Requests

The Alliance Formulary is a list of covered drugs developed and managed by MedImpact. Covered drugs are selected by physician and pharmacist subject matter experts who collaboratively support MedImpact's Pharmacy and Therapeutics (P&T) Committee. To find out if a particular drug is covered, please refer to the [Alliance Formulary](#). A copy of the formulary may be downloaded directly from the [Pharmacy page](#) on the Alliance provider website.

Drugs that are not covered on the formulary, or drugs on the formulary with restrictions such as prior authorization (PA), step therapy, or quantity limits may require a prior authorization review to determine coverage for medical necessity. Prior authorization requests must be submitted to MedImpact, not to the Alliance. [Prescription Drug Prior Authorization or Step Therapy Exception Request Form \(California Form 61-211\)](#) is available on [Pharmacy page](#) on the Alliance provider website or [Form Library](#). Submissions on other forms will not be accepted. Submissions on other forms will not be accepted.

PA requests must be submitted to MedImpact via the following methods:

- Fax 858-790-7100
- MedImpact ePA Program
- United States (US) Mail

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131

Additional information is available on [MedImpact website](#) at <https://www.medimpact.com/forclients/healthcare-provider-welcome> or by calling MedImpact at 800-788-2949.

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After Hours Access and Emergency Supply

24-hour access is provided by any 24-hour pharmacy that contracts with the Alliance's Pharmacy Benefit Manager (PBM), MedImpact. To find a pharmacy, search in [MedImpact's Pharmacy Directory](#).

MedImpact is authorized to enter an override for a five-day emergency supply of any medication if the pharmacy states that it is for an emergency. The Alliance will receive and retrospectively review a report of all emergency overrides placed by MedImpact. MedImpact can be reached at 800-788-2949.

Physician-Administered Drugs

Some Physician/Facility-Administered Drugs (PADs) billed as a medical claim may require a prior authorization (PA). [Prior authorization \(PA\) criteria](#) are based on the recommendations of the Alliance Pharmacy and Therapeutics (P&T) Committee, and are available on the [Pharmacy page](#) on the Alliance provider website. If a Physician-Administered Drug does not have PA criteria, it will be reviewed for medical necessity based upon Alliance policies as well as nationally recognized standards. For more information on the authorization review process for PADs, please see Policy [403-1141 – Physician/Facility-Administered Drugs Requiring Prior Authorization](#)

The Alliance will prefer the use of a Biosimilar over its branded biologic counterpart. For more information, please see Policy [403-1142 - Biosimilars](#).

For providers who wish to administer Synagis in their office, the [Synagis 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](#).

Medi-Cal Carved-Out Drugs

For Medi-Cal members, the Alliance does not cover drugs used for treatment of HIV/AIDS/Hepatitis B, alcohol and heroin detoxification and dependency, clotting factor disorder, and antipsychotic drugs listed on pages 5-9 of the [MCP: County Organized Health System file](#). These carved-out or non-capitated drugs should be billed to Fee-For-Service (FFS) Medi-Cal. Medi-Cal.

Submitting Authorization Requests for Physician-Administered Drugs

Authorization requests for Physician-Administered Drugs billed as a medical claim may be submitted to the Alliance via the methods listed below. Submission of PA requests is preferred through the [Alliance Portal](#). If faxed or mailed, prior authorization requests must be submitted on the [Prescription Drug Prior Authorization Request Form](#) or [Treatment Authorization Request \(TAR\) Form](#) for all Alliance members. The forms can be found on the [Pharmacy page](#) on the Alliance provider website or [Form Library](#).

- [The Alliance Provider Portal](#) (preferred)

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- Fax 831-430-5851
- United States (US) Mail

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:

1. Member name, ID number and DOB.
2. Requesting provider name and contact information.
3. Description of requested drug or item (must include Healthcare Common Procedure Coding System (HCPCS) code if physician or facility administered drug is requested).
4. Prescriber name, NPI, address, phone number and fax number.
5. Servicing provider name, NPI, address, phone number and fax number (if different).
6. Diagnosis (or ICD code) that most accurately describes the indication for the medication. Please include all medically relevant diagnoses for review purposes.
7. Quantity requested per fill or per date of service (DOS) (in “quantity” field).
8. Number of fills or DOS requested (in “units” field).
9. Directions for use.
10. Expected duration of therapy.
11. 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 preferred alternatives 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.

Providers can contact the Alliance Pharmacy department at 800-700-3874, ext. 5507.

Section 16. Pharmacy Services

For more information on the authorization review process, please see Policy [403-1103 - Pharmacy Authorization Request Review Process](#).

Continuity of Care for New Members

In the event that a new member is being treated with a 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](#).

The Alliance has developed policies in collaboration with internal and external stakeholders to help ensure the safe and appropriate use of opioid medications. For Alliance Care IHSS members, 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 the early refill. For Medi-Cal members, please refer to Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov. For more information on the Opioid Utilization Review process, please see Policy [403-1139 - Opioid Utilization Review](#).

Billing and Reimbursement

For Medi-Cal members, the Alliance does not cover drugs used for treatment of HIV/AIDS/Hepatitis B, alcohol and heroin detoxification and dependency, clotting factor disorder, and antipsychotic drugs listed on pages 5-9 of the [MCP: County Organized Health System](#) file. These carved-out or non-capitated drugs should be billed to Fee-For-Service (FFS) Medi-Cal. Procedures for Fee-For-Service reimbursement for carved-out drugs can be found on the [Medi-Cal website](#) in the Part 2 manual for [Pharmacy](#).

For information on how to obtain reimbursement for compounding drugs, please see Policy [403-1135 - Compounded Drugs Requiring Special Handling](#).

For information on billing for drug waste, please see Policy [403-1146 - Drug Waste Reimbursement](#)

The Alliance 340B Pharmacy Program

For information on billing for drugs purchased under the 340B program, please see Policy [403-1145- Pharmacy 340B Program](#).

Additional Pharmacy Benefits

Enteral Nutrition Product Benefit

Enteral Nutrition Products that are billed as a pharmacy claim are transitioned from the Alliance pharmacy benefit to Medi-Cal Rx for Medi-Cal members. Enteral nutrition formulas, including nutrition support (tube feed) formulas, oral nutrition supplements and specialty infant formulas, can only be billed on a pharmacy claim. Refer to the [List of Covered Enteral Nutrition Products](#) on Medi-Cal Rx website www.Medi-CalRx.dhcs.ca.gov. Prior authorization requests for Enteral Nutrition Products that are billed as a pharmacy claim must be submitted to Medi-Cal Rx. For more details about Medi-Cal Rx, refer to “Outpatient Pharmacy Services” above.

For other Enteral Nutrition Products that are billed as a medical claim, prior authorization is required to be submitted to the Alliance. Prior authorization requests can be submitted by the prescribing or servicing provider, and may be submitted via the [Provider Portal https://thealliance.health/for-providers/provider-portal/](https://thealliance.health/for-providers/provider-portal/) or fax 831-430-5851. 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 are outlined in [Policy 403-1136 – Enteral Nutrition Products](#) and [Attachment A – Procedure and Assessment for Medical Necessity Determination of Enteral Nutrition Products](#).

Medical Nutrition Therapy

Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (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- -Code 97802 - MNT, initial assessment and intervention, individual, face-to-face with patient, each 15 minutes.
- CPT--Code 97803 - MNT, re-assessment and intervention, individual, face-to-face with patient, each 15 minutes.
- CPT- -Code 97804 - MNT, group (2 or more individual (s), each 30 minutes.
- CPT – 4-Code G0270 – MNT: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
- CPT – 4-Code G0271 – MNT, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
- HCPCS Code S9470 – Nutritional Counseling, dietitian visit, each 15 minutes
- CPT- Code T1014 - Telehealth if applicable

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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;

- Pediatric obesity with a BMI >95th percentile
- Cancer with significant weight loss
- Pre-Post bariatric surgery
- Conditions impairing digestion and absorption
- Underweight status or unintended weight loss

For more information on MNT, please see Policy [403-1149 - Medical Nutrition Therapy](#).



Section 17

Resolution of Disputes and Grievances

Alliance members and both contracted and non-contracted providers may access the Alliance Dispute and 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 Provider Inquiry Form (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, 8:30 AM-4:30 PM.

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

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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.

Inquiries and disputes must include the following information:

1. Provider name.
2. Provider NPI, Tax ID, or Alliance ID number.
3. Provider contact information.
4. A clear explanation of the issue in question.
5. Your position on the matter.
6. If the inquiry or dispute involves a claim or request for reimbursement of overpayment, you also must include:
 7. The contested claim number, and all other claim control numbers if there have been multiple resubmissions of the claim.
 8. A clear identification and description of the contested item.
 9. The date of service.
 10. A clear explanation of why you believe the payment or other action is incorrect.
11. 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 is denied for lack of information?

Section 17. Resolution of Disputes and Grievances

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 claim's 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 grievance 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 services 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. Providers may not retaliate against a member for filing a complaint. In addition, providers must cooperate with the Alliance in identifying, processing and resolving all member grievances/complaints and appeals. Cooperation includes but is not limited to:

- Speaking with Alliance representatives to assist in resolving the grievance or appeal in a reasonable manner.
- Having designated staff available to review grievance and appeal investigations.
- Completing a provider response in writing if requested. Providers may submit a response in writing and often provide written documentation of their requests when filing on a member's behalf.

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- Responding to all information or documentation requests made by the Plan related to a grievance or appeal, such as: medical records request, provider's response to a complaint, scheduling documentation/Phone logs, policies or other supporting documentation to support the review.
- Responding to requests timely (typically within seven (7) business days).
- Taking all reasonable actions suggested by our staff to resolve the members' 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 grievance or appeal. A grievance may be filed by a member or a member's authorized representative:

- 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: (800) 735-2929. Spanish TTY line: (800) 855-3000
- 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

Section 17. Resolution of Disputes and Grievances

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981

- Electronically, by visiting the File a Grievance page on the Alliance [website](#).

When the Plan receives a grievance, 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 grievance, notify the member of their rights in the Grievance Process, and tell the member that we will send a proposed resolution letter within thirty (30) calendar days from the date the grievance was received.

In some cases, members do not need to use the Alliance Grievance System to resolve their complaint or appeal. Refer to the Alliance Grievance Process 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 request 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, also known as Aid Paid Pending (APP) 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 grievance or if a grievance remains unresolved after thirty (30) days.

Alliance Care IHSS members also have the right to request an Independent Medical Review (IMR) if their grievance involves a denial or partial denial of a health care service that was determined not to be medically necessary.

FAQs to Providers for Member Grievances and Member Appeals

What is the Alliance Member Grievance System?

This is the system for resolving member grievances/complaints and appeals about the services a member receives as an Alliance member. Filing a grievance or appeal will not affect a member's health care coverage

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through the Alliance. Filing a grievance 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 grievance/complaint if they:

- Encounter delays receiving health care services that the member thinks they need such as medications, medical equipment, referrals to specialists, or doctors' appointments.
- Are unhappy with the services they received from a health care provider.
- Are unhappy with any aspect of their health care.
- Received a bill from a provider.
- 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 received a 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 grievance 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.

What if the member speaks a language other than English?

The Alliance has staff who speak Spanish and Hmong. The Alliance 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 one hundred and twenty (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 **800-743-8525 (TDD: 800-952-8349)** to request a hearing or can fax their request to DSS to **833-281-0905**.

A member may request a hearing online at WWW.CDSS.CA.GOV or email their request to SCOPEOFBENEFITS@DSS.CA.GOV

A member may mail their request to:

California Department of Social Services State Hearings Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

A member can also ask for a hearing at any of these local offices:



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Santa Cruz County:

Human Services Dept
1020 Emeline Street
Santa Cruz, CA 95060
831-454-4117

1000 South Main Street, Suite
208
Salinas, CA 93901
831-755-4477

Attn: Hearing Coordinator
2115 West Wardrobe Avenue
Merced, CA 95341
209-385-3000

Monterey County:

Department of Social Services

Merced County:

Merced County Human
Services Agency

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:

U. S. Department of Health and Human Services

Office of Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

What if the member needs help to file their grievance or appeal?

The member can authorize another person such as a family member or a friend to help them. The member can call the State Office of the Ombudsman at **888-452-8609** if the member has Medi-Cal. The member can also call the California Health Consumer Alliance at **888-804-3536** if member needs legal help.

What happens after a member files a grievance or appeal?

The Alliance Grievance staff will send the member a letter within five (5) days after a member files a complaint or appeal. This letter tells the member that the plan received the grievance and explains the member's rights in the grievance process.

How is the grievance or appeal resolved?

Depending on the type of grievance or appeal made, Alliance staff may be able to resolve it very quickly. If this is not possible, we will work with internal Alliance departments and 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 staff 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 staff will send the *proposed resolution letter* within thirty (30) days from the day the grievance was received.

What if the grievance or appeal involves a serious threat to their health?

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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, then Grievance staff will inform the member within twenty-four (24) hours that the grievance has been received. A resolution will be completed within 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 the member is an In-Home Supportive Services (IHSS) member, then the following California Department of Managed Health Care statement below applies:**

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 (800) 700-3874 or TTY (800) 735-2929 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 an 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.dmhca.ca.gov has complaint forms, IMR application forms, and instructions online.



Section 18

Member and Provider Incentives

This section includes information on the Primary Care Provider (PCP) and Member incentive programs offered by the Alliance in 2023. 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.

Primary Care Physician Incentives and Resources 2023

Care-Based Incentive Program 2023 Overview

The Alliance's Care-Based Incentive (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.
- Health Equity Measure.
- Practice Management.

Although the CBI Program evaluates performance on the Alliance's Medi-Cal line of business, the Alliance encourages high 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.

For more information about the CBI Program, please see Policy [401-1705 – Care Based Incentive Program](#).

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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 four categories of measures: (1) Care Coordination Measures, (2) Quality of Care Measures, (3) Health Equity Measure, and (4) 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 the [CBI Resources page](#) on the Alliance website.

Care Coordination (CC) Measures: Care Coordination – Hospital & Outpatient Measures, a Provider's performance for Ambulatory Care Sensitive admissions (ACSA) and Preventable Emergency Visits is compared to the performance of providers within the same comparison group (i.e., Family Practice, Internal Medicine or Pediatrics). The Plan All-Cause Readmissions is compared to an Alliance defined standard.

Under the Care Coordination–Access Measures, a Provider's performance for the Initial Health Assessment and Post Discharge Care measures are compared to the performance of providers within the same comparison group (i.e., Family Practice, Internal Medicine or Pediatrics). The Application of Dental Fluoride Varnish, Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents, and Developmental Screening in the First Three Years is based on their rate of achievement under each measure.

To qualify for the Care Coordination – Access Measures, which include Application of Dental Fluoride Varnish, Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents, Developmental Screening in the First Three Years, Initial Health Assessment (IHA), 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 & Outpatient Measures, which include Ambulatory Care Sensitive admissions (ACSA), Plan All-Cause Readmissions and the Preventable Emergency Visits, Providers must have 100 eligible linked members, on average, during the 2023 calendar year or 100 linked members as of December 31, 2023. Continuous enrollment requirements also apply to all care coordination measures. California Children's Services (CCS) members are excluded from Care Coordination – Hospital & Outpatient measures.

Visit the CBI Tip Sheet section of the [CBI Resources page](#) of the Alliance provider website for a list of diagnosis included in the Ambulatory Care Sensitive Admissions (ACSA) and the Preventable Emergency Visits measures.

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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 and include one of the CMS Core Measure Set (Adult Core Set) for the Screening for Depression and Follow-Up Plan measure using an Alliance defined benchmark. For a provider to receive points for a QoC Measure, they must have a minimum of 30 eligible linked members that qualify for the measure based on HEDIS and CMS Core Measure (Adult Core Set) specifications. The 9 QoC Measures for 2023 are shown below.

1. Body Mass Index Assessment: Children & Adolescents.
2. Breast Cancer Screening.
3. Cervical Cancer Screening.
4. Child and Adolescent Well-Care Visits (3-21).
5. Diabetic HbA1C Poor Control >9.0%.
6. Immunizations: Adolescents.
7. Immunizations: Children (Combo 10).
8. Screening for Depression and Follow-up Plan.
9. Well-Child Visits in the First 15 Months.

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. The measures that qualify for Performance Improvement for 2023 are listed in the CBI Table below.

Exploratory Measures: The Exploratory Measures are a part of the CBI Program to monitor performance and are considerations for possible inclusion as a paid measure in the 2024 CBI Program. These measures do not qualify for payment in 2023. The Exploratory Measures are shown below:

1. Chlamydia Screening in Women.
2. Colorectal Cancer Screening.
3. Controlling High Blood Pressure. Immunizations: Adults.
4. Lead Screening in Children.

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CBI Table

Care Coordination Measures:						
CBI Programmatic Incentive Measurement Components	Available Points	Member Requirement	Benchmark Ranking/ Rate of Achievement	Measurement Period	Measurement Data Source	Methodology
All Care Coordination Measures:	47 total					
<u>Plan All-Cause Readmissions</u> Percentage of acute inpatient and observation stays that were followed by an unplanned readmission of an Eligible Member within thirty (30) days of discharge during the CBI Term.	10.5	100 Eligible Members on average or as of December 31, 2022	Alliance defined ≤25.00%	FY 2022	Claims data	CBI Contract 3.1.4 NCQA HEDIS®
<u>Ambulatory Care Sensitive Admissions</u> Number of Ambulatory Care Sensitive Admissions per 1,000 Eligible Members per Fiscal Year.	7					CBI Contract 3.1.2 AHRQ ¹
<u>Preventable Emergency Visits</u> Number of preventable emergency department and preventable Urgent Visits per 1,000 Eligible Members per Fiscal Year.	8		2.5% Improvement over Comparison Group's 2019 median Measurement Year performance			CBI Contract 3.1.3 Medi-Cal State Collaborative adapted definitions from the NYU study ²

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Care Coordination Measures:						
<u>Post-Discharge Care</u> Number of post-hospital discharge visits per number of Eligible Members linked at end of Fiscal Year.	10.5	≥ 5 Eligible Members linked to Provider				CBI Contract 3.1.5
<u>Initial Health Assessment</u> Number of Initial Health Assessments per number of Eligible Members linked at end of Fiscal Year.	4			October 1, 2022 – December 31, 2023		CBI Contract 3.1.6
<u>Developmental Screening in the First Three Years</u> The percentage of children linked to a CBI Provider, who turned 1, 2, or 3 during the Measurement Period who were screened for risk of developmental, behavioral and social delays.	2		2023 Rate of Achievement	FY 2023	Claims and Data Submission Tool (DST) data	CBI Contract 3.1.7 CMS Core Measure Set (Child Core)
<u>Application of Dental Fluoride Varnish</u> Percent of Eligible Members ages six (6) months to five (5) years (up to before their 6 th birthday) linked to Provider during the final month of the CBI Term that received a	2					CBI Contract 3.1.9

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Care Coordination Measures:						
fluoride varnish within the Measurement Period						
Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents	3				Claims data	CBI Contract 3.1.8

Quality of Care Measures: (NCQA HEDIS® and CMS Core Measure Set [Adult Core])						
CBI Programmatic Incentive Measurement Components	Available Points	Member Requirement	Benchmark Ranking/Rate of Achievement	Measurement Period	Measurement Data Source	Methodology
All Quality of Care Measures:	38 total					
Body Mass Index Assessment: Children & Adolescents	CBI Contract 3.2.2	≥30 continuously Eligible Members ⁴	NCQA HEDIS® Quality Compass National Rankings ⁵ (Plan Benchmark is the HEDIS national 50 th percentile, and Plan Goal is the HEDIS national 90 th percentile)	NCQA HEDIS®	Claims in paid or denied status, lab test results, BMI value and percentiles, and other NCQA recommended supplemental data sources, DST	CBI Contract 3.2.1 NCQA HEDIS®
Breast Cancer Screening						
Child and Adolescent Well-Care Visits						
Cervical Cancer Screening						
Diabetes HbA1c Poor Control >9%						
Immunizations: Children (Combo 10)						
Immunizations for Adolescents						
Well-Child Visit in the First 15 Months						
Screening for Depression and Follow-up Plan			Alliance defined ≥7.00%	CMS Core Measure	Claims	CBI Contract 3.2.1

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Quality of Care Measures: (NCQA HEDIS® and CMS Core Measure Set [Adult Core])						
				Set (Adult Core)		CMS Core Measure Set (Adult Core)

Performance Target Measures						
CBI Programmatic Incentive Measurement Components	Available Points	Member Requirement	Performance Target	Measurement Period	Measurement Data Source	Methodology
All Performance Improvement Measures:	<i>10 total</i>					
Care Coordination – Hospital & Outpatient (Ambulatory Care Sensitive Admissions, Preventable Emergency Visits) – a 5% reduction in rate for applicable Care Coordination Measures or achievement of the Plan Goal. Plan All-Cause Readmission will require 5 percentage points over prior Measurement Period or achievement of the Plan Goal.	10	Care Coordination: CBI Contract 3.1.1	Plan Goal or requisite improvement over Provider's FY2022 performance	CBI Contract 3.3.3.1 and FY 2023 compared to FY 2022	CBI Contract 3.3.3.1	CBI Contract 3.3.3.1
Care Coordination – Access (Adverse Childhood Experiences [ACEs] Screening in Children and Adolescents ⁶ , Developmental Screening in the First Three Years, Initial Health Assessment, and Post Discharge Care) - an improvement of 5 percentage points over prior Measurement Period or achievement of the Plan Goal.)						

Section 18. Member and Provider Incentives

Performance Target Measures						
Quality of Care (Body Mass Index [BMI] Assessment: Children & Adolescents, Breast Cancer Screening, Cervical Cancer Screening, Child and Adolescent Well Care Visits, Diabetic HbA1c Poor Control > 9%, Immunizations: Children (Combo 10), Immunizations: Adolescents, Screening for Depression and Follow-up Plan, Well-Child Visits in the First 15 Months an improvement of 5 percentage points over prior Measurement Period or achievement of the Plan Goal.		Quality of Care: ≥30 continuously Eligible Members ⁴				

Health Equity Measure			
CBI Programmatic Incentive Measurement Component	Available Points	Member Requirement	Methodology
Health Equity	5	N/A	CBI Contract 3.4

CBI FFS Incentives			
Measurement Component	Amount Paid Quarterly	Member Requirement	Measurement Data Source
<u>Adverse Childhood Experiences (ACEs) Training and Attestation</u> An additional payment is available for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying medical practioners , for completing the ACEs training and attestation.	\$200 one-time payment after receipt of State notification of training and attestation completion.	None	CBI Contract 4.3
<u>Patient Centered Medical Home Recognition</u> Provider to submit documentation substantiating Provider's achievement of NCQA PCMH recognition or TJC certification.	\$2,500 for PCMH recognition/certification.	None	CBI Contract 4.1 Documentation from NCQA or TJC

Section 18. Member and Provider Incentives

Behavioral Health Integration An additional payment is available for documentation of behavioral health integration through NCQA Distinction in Behavioral Health.	\$1000 for behavioral health integration distinction	None	CBI Contract 4.2 Documentation from NCQA
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¹ https://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx#techspecs and https://www.qualityindicators.ahrq.gov/Modules/pdi_resources.aspx#techspecs Excluding NQI 03 and PDI 01, 05, 08-12

² The list of preventable emergency department and urgent visit diagnosis that are used to calculate this measure are linked on the Plan's website: <https://thealliance.health/for-providers/manage-care/quality-of-care/care-based-incentive/care-based-incentive-resources/preventable-emergency-care-visit-diagnosis-tip-sheet/>³ <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions>

⁴For NCQA HEDIS® measures, the continuously Eligible Members must be qualified per HEDIS specifications.

⁵ If no NCQA HEDIS® Quality Compass benchmark is published for a Quality of Care Measure, the calculation of that Quality of Care Measure shall be explained in the Provider Manual

⁶ Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents will meet the performance improvement measure by meeting or exceeding the Plan Goal only.

Note 1: Should a CBI Provider reassign members at a rate higher than one reassignment per 150 Eligible Members linked to such CBI Provider, based upon the CBI Provider's average linkage throughout the CBI Term (the "Member Reassignment Threshold"), points awarded to the CBI Provider under the CBI Programmatic Incentive will be reduced by fifty percent (50%). The Member Reassignment Threshold is not applied if the CBI Provider has either (i) less than an average of one hundred (100) Eligible Members, as determined by the number of months for which the CBI Provider was contracted during the Measurement Period or (ii) less than one hundred (100) Eligible Members as of December 31, 2023.

Note 2: References to Section numbers in this Attachment 1 are to section numbers of Addendum 3 unless otherwise specified.

CBI Programmatic Measure Benchmarks

The 2023 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, 2) total number of eligible member months, 3) risk stratification score and 4) distribution

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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 [Programmatic Measure Benchmarks & Performance Improvement](#) 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 2023 for the measures shown below.

1. Adverse Childhood Experiences (ACEs) Training and Attestation.
2. Behavioral Health Integration.
3. Patient Centered Medical Home (PCMH) Recognition.

For more information on the CBI FFS measures, including incentive payment amounts, visit the [CBI Incentive Summary page](#) or [CBI Technical Specifications page](#) in the [CBI Resources](#) section of the Alliance Website.

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 Payment Adjustments

A payment adjustment is included in the 2023 CBI program to align with State performance expectations for the Quality of Care Measures. Medi-Cal Plans must meet or exceed the 50th percentile for State reported metrics. If the health plan doesn't meet the 50th percentile in one or more measures, they may be required to complete a Plan, Do, Study Acts, (PDSAs); assigned a Corrective Action Plans (CAPs); or be sanctioned (including financial penalty).

Payment will be adjusted for qualifying Quality of Care Measures where CBI Provider's performance falls below the 50th percentile. The Quality of Care Performance adjustment will only apply to measures where a CBI

Section 18. Member and Provider Incentives

Provider has a total of thirty (30) Eligible Members that qualify for the Measurement Component. For Quality of Care measures below the 50th percentile, payment will be adjusted as follows:

Tier	Performance <50 TH Percentile	CBI Programmatic Payment Adjustment
1	1-3 metrics >25 th and <50 th percentile and no metrics <25 th percentile	CBI Programmatic Incentive Payment reduction of 25%
2	>4 metrics >25 th and <50 th percentile and no metrics <25 th percentile	CBI Programmatic Incentive Payment reduction of 50%
3	1-3 metrics <25 th percentile	CBI Programmatic Incentive Payment reduction of 75%
4	4 or more metrics <25 th percentile	No CBI Programmatic Incentive Payment

CBI Resources

The Alliance's website includes information on the CBI program including [what's new for the Care-Based Incentive program](#) and [CBI resources](#). On the CBI Resources page, you can find:

- [CBI Technical Specifications](#) – This resource is the most comprehensive guide for the CBI program this year.
- [CBI Incentive Summary](#) – The incentive summary provides an overview of the CBI program.
- [CBI Tip Sheets](#) – The CBI Tip Sheets are quick reference guides specific to each CBI measure.

The Alliance's [Provider Portal](#) is a resource that offers monthly Quality Reports using applicable claims, laboratory data, immunization registry data (RIDE and CAIR), and DST data received for measures to assist providers in monitoring their patients. The quality reports have linkage at the population level, with no continuous enrollment criteria, and may include a prospective report design different from the CBI measures. 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, and 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 information on how to upload the data. The Alliance is accepting data for the following measures:

- Application of Dental Fluoride Varnish.
- Breast Cancer Screening (includes bilateral mastectomy codes).

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- Body Mass Index (BMI): Child and Adolescents.
- Cervical Cancer Screening (includes cervical cytology, high-risk human papillomavirus [hrHPV], and total abdominal hysterectomy codes).
- Chlamydia Screening in Women.
- Controlling High Blood Pressure.
- Developmental Screening in the First 3 Years of Life.
- Diabetic HbA1c Poor Control >9%.
- Immunizations for Children, Adolescents, and Adults.
- Initial Health Assessments (IHA).
- Screening for Depression and Follow-Up Plan
- Well-Child Visits in the First 15 Months of Life.
- Unhealthy Alcohol Use in Adolescents and Adults.

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

For Fiscal Year 2019-2020 the Governor's Budget proposed a Value-Based Payment Program (VBP) through Medi-Cal managed care health plans (MCPs) to provide incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. This program directed funding from Proposition 56 to be used in accordance with the Department of Health Care Services (DHCS) payment methodology finalized in [APL 20-014](#). DHCS started making payments to MCPs for administration of the program in July 2020 for the program implementation date of July 1, 2019, for all measures. The program has since ended effective June 30, 2022. Services performed after June 30, 2022, will not be eligible to receive VBP enhanced payments. Claims for VBP services received up to one year after the date of service will continue to be paid if the date of service for the claim was by June 30, 2022. An update to the All-Plan Letter will be released by DHCS to reflect the program end date of June 30, 2022.

VBP Payments

To address health disparities, an enhanced payment factor has been allocated for members diagnosed with substance use disorder (SUD), serious mental illness (Schizophrenia, Bipolar Disorder, Other Bipolar Disorder, and Major Depression), or homeless or inadequate housing as defined in DHCS's specifications. The SUD and SMI at-risk populations will be determined by encounter data with an approved diagnosis code for a date of service during the measurement year. The diagnosis of homeless or inadequate housing will need to be on the encounter for the VBP eligible service. **Payments are based on Medi-Cal receiving the claims and encounter data** and will be paid to eligible Network Providers. Network Providers must meet criteria in [APL](#)

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[19-001](#), possess an individual (Type 1) National Provider Identifier (NPI), as well as be practicing within their scope. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics are not eligible Network Providers for the VBP program.

Claims for VBP services received up to one year after the date of service will continue to be paid if the date of service for the claim was by June 30, 2022. For additional information on the VBP program, please see the [DHCS VBP website](#).

Provider Resources and Support

Kinetic Quality Improvement

Practice Coaching

Consistent with the Alliance's mission of accessible, quality health care guided by local innovation, the Alliance works to identify solutions to produce positive outcomes for our members. As we work to advance our vision of active leadership in achieving healthcare solutions, we want to actively engage with and support individual clinics in QI work. Specifically, we seek to partner with network primary care practices to pursue the "Quadruple Aim": improving the health of populations, enhancing the experience of care for individuals, reducing the cost of health care, and attaining joy in work.

Goals:

- Engage with primary care office managers, administrators, providers, medical assistants, and other staff to organize and prioritize QI activities
- Cultivate collaborative relationships between the Alliance QI/PH Team and network providers and staff
- Support practice teams in QI project implementation and building/enhancing their QI infrastructure
- Increase the capacity of practices to utilize and make changes based on performance data
- Provide resources and information to disseminate best practices

Expectations of the Clinic:

1. Leadership will support and encourage engagement with the Alliance QI Team.
2. Staff will work collaboratively with the Alliance QI Team to identify and prioritize QI needs.
3. Involved leaders will make reasonable accommodations to regularly meet with Alliance QI Team members and provide information/resources needed to carry out activities
4. Staff and leadership will provide all requested feedback on the engagement

Benefits to the clinic:

- On-site support from staff trained in QI methods and PCMH-focused primary care change concepts.
- Technical assistance to optimize data and EHR utilization.

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- Hands-on help with advancing QI projects and activities of interest related to workflow development, tracking progress, evaluating PDSAs and other project-related tasks.
- Actionable, evidence-based recommendations and feedback tailored to the clinic's specific needs.
- Access to QI-related tools and assistance with selecting/adapting resources for the clinic's use.
- Enhanced connections with Alliance resources.

For additional questions about the practice coaching program please email us at pc@ccah-alliance.org

Practice Transformation Academy

The Practice Transformation Academy (PTA) was developed to provide instruction in quality improvement (QI) methodology to primary health care clinics and staff. Our goal is to teach a framework for problem solving that will help guide clinics as they work toward improving the patient experience, population health, care team satisfaction, clinical workflows and performance. The PTA team is focused on offering an ongoing series of training through a variety of modalities such as in-person workshops, webinars, and eLearning series, to meet clinic and staff needs.

Virtual Learning Series: The ABC's of Quality Improvement

The pandemic has brought about a lot of changes in primary care and the need to implement meaningful improvement projects with effectiveness and efficiency has never been greater. Therefore, to support our clinics safely, we have created a video learning series on the Basics of Quality Improvement. The videos on topics like SMART Aim Statements, Project Charters and Process Mapping can be accessed on the Alliance's provider website at https://thealliance.health/training_type/practice-transformation-academy/

Each video introduces key concepts and tools that are integral to an improvement project. The tools we cover in detail are also available for download. If you have any questions about the material covered, or if you need help starting an improvement project, please email us at pc@ccah-alliance.org for assistance.

Learning Collaboratives

Learning Collaboratives are interactive face-to-face meetings with other providers and staff across the network to come together and share best practices on a selected topic. Individuals included in our learning collaboratives include clinics, hospitals, specialists and Alliance staff. During this roundtable, we explore methods to improve CBI scores as well as discuss techniques to address barriers in healthcare.

Member Incentives 2023

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

Immunizations: Adolescents

Adolescent members turning 13 years of age who have received the following vaccinations by the time of their 13th birthday will be entered into a monthly raffle to win a \$50 gift card:

1. 1 dose meningococcal conjugate
2. 1 dose tetanus, diphtheria, and pertussis (Tdap)
3. 2 doses of human papillomavirus (HPV)

Immunizations: Childhood Flu

Children ages 7 to 24 months who complete both flu shot doses between September and May will be entered into a monthly raffle for a \$100 Target gift card. Raffles will occur November through July.

Immunizations: Children

Toddler members turning 2 years of age who have received all of the following vaccinations by their 2nd birthday will be entered into a monthly raffle to win a \$100 gift card:

- 4 diphtheria, tetanus, acellular pertussis (DTaP);
- 3 inactivated polio vaccine (IPV);
- 1 measles, mumps and rubella (MMR);
- 3 haemophilus influenza type B (HiB);
- 3 hepatitis B (HepB);
- 1 varicella (VZV);

Section 18. Member and Provider Incentives

- 4 pneumococcal conjugate (PCV)
- 2 or 3 rotavirus (RV)
- 1 hepatitis A (HepA)
- 2 influenza (Flu)

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.

Well-Child Visits First 15 Months of Life

- Members who are 15 months old and have completed their well-child visit, in alignment with the schedule below, are eligible to be entered into a monthly raffle to win a \$25 gift card:
- 5 days old
- 1 month old
- 2 months old
- 3 months old
- 4 months old
- 6 months old
- 12 months old
- 15 months old
- Members who are 15 months old and have completed 6 or more well-visits by 15 months of age will be eligible to be entered into a yearly raffle to win a \$150 gift card.

Section 19

Forms



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.

Section 19. Forms

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.

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.

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.

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Physician Orders for Life-Sustaining Treatment (POLST) (English, Spanish, Hmong) - This form is designed to support 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 or Step Therapy Exception Request Form – Providers can use this form to request prior authorization for medications and Physician-Administered Drugs.

Request for Administrative Member Classification – Providers can use this form to request that an Alliance member be made an administrative member.

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.

Section 19. Forms

Request for Member Reassignment - Forms, procedures, and member notices to be used when requesting member reassignment.

2023



Questions about The Central California Alliance for Health?

Call your Provider Services Representative at
800-700-3874 ext. 5504

1600 Green Hills Road, Suite 101 • Scotts Valley, CA 95066-4981 • 831-430-5500
950 East Blanco Road, Suite 101 • Salinas, CA 93901-4419 • 831-755-6000
West 16th Street, Suite B • Merced, CA 95340-4710 • 209-381-5300

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