ALAMEDA ALLIANCE FOR HEALTH

LONG-TERM CARE (LTC) DEPARTMENT NURSING FACILITY RESOURCE GUIDE

Introduction

Welcome to the Alameda Alliance for Health (Alliance) provider network! We appreciate your partnership in helping fulfill our mission to improve the health and well-being of our members by collaborating with our provider and community partners to deliver high-quality and accessible services. Together, we can help make our community a healthier and safer place for all.

We created this Long-Term Care (LTC) Nursing Facility Resource Guide to help provide key information for you and your staff in working with the Alliance. We aim to ensure that your relationship with us works well for you, your staff, and Alliance members. More information is available in your Alliance contract, the Alliance Provider Manual, and on our website **www.alamedaalliance.org**.

The information in this guide is subject to change. For the most up-to-date information, please refer to the Nursing Facility Resource Guide available on the Alliance website. You can also call the Alliance Long-Term Care (LTC) Department at **1.510.747.4516**.

For clarification, questions, or comments about your role as an Alliance provider, please call the Alliance Provider Services Department at **1.510.747.4510**.

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Welcome to the Alliance Provider Network!

Thank you for being a part of the Alameda Alliance for Health (Alliance) provider network! The Alliance contracts with individual practitioners, medical groups, hospitals, and other non-hospital facilities to provide high-quality health care and services to our members.

The Alliance is a local, public, not-for-profit, managed care health plan committed to making high-quality health care services accessible and affordable to Alameda County residents. For over 25 years, the Alliance has worked to provide programs and services you can trust and count on. The Alliance is honored to serve more than 300,000 children and adults throughout Alameda County.

Our Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high-quality and accessible services.

Our Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life. We provide services through two (2) lines of business:

1. **Alliance Group Care:** An employer-sponsored group health plan for In-Home Supportive Services (IHSS) workers.
2. **Medi-Cal**: Affordable insurance for families, children, persons with disabilities, and seniors.

Section 1. Overview and Purpose

The Long-Term Care (LTC) Nursing Facility Resource Guide was created by the Alliance Long-Term Care (LTC) Department. It is intended to assist you with understanding the administrative processes related to providing facility-based LTC to Alliance members. Our goal is to make this guide as helpful as possible. The purpose of the guide is to provide information and resources that will be useful in coordinating services for Alliance members. This guide provides instructions for obtaining authorizations and receiving payment for LTC nursing facility services.

This guide is supplemental and does not replace nor supersede, the Agreement between you and the Alliance. Updates to this guide will be made periodically in accordance with the Agreement and in response to changes in operational systems and regulatory requirements. In the event of any discrepancy between the terms of this guide and the Agreement, the terms of the Agreement will govern.

Your partnership with the Alliance is vital to our relationship. We welcome and encourage comments and suggestions about this guide or any other aspect of your relationship with the Alliance.

Model of Care

Nursing facilities play an important role in the ongoing support of our most vulnerable members. The Alliance will directly contract with facilities that offer LTC. The Alliance LTC nursing facility provider network includes Medi-Cal licensed and certified nursing facilities, also known as skilled nursing facilities (SNFs).

Nursing facility services are provided by certified nursing homes, which primarily provide three (3) types of services:

1. ***Skilled nursing*** – Provides treatment of medical conditions.
2. ***Rehabilitation*** – Restores functional abilities due to injury, disability, or illness.
3. ***Long-term care*** – Care for physical or mental conditions that need continuous skilled nursing services. For Medi-Cal managed care, the LTC benefit for these services includes room and board, and other covered services medically necessary for care.

Section 2. Member Eligibility Verification

Tools for Verifying Member Eligibility

Verifying member eligibility is essential to successfully coordinating and receiving payment for covered services. All Alliance members are issued identification (ID) cards, however, member eligibility and the current benefits available to members should always be verified before providing care. Eligibility and PCP/medical group assignments can change from month to month.

This section provides information and guidelines about how to verify Alliance eligibility, what to watch for, and how changes could affect payment.

Medi-Cal and Alliance Member ID cards

The Alliance does not determine Medi-Cal eligibility. Medi-Cal eligibility and assignment to the Alliance are determined by the State of California.

The State of California provides a Benefits Identification Card (BIC) to each Medi-Cal beneficiary. In addition, all Alliance members are issued a member ID card. Alliance medical groups also issue their members a separate member ID card.

Please Note: A member's possession of an Alliance member ID card does not guarantee current membership with the Alliance or with the participating physician group identified in the card.

Determining Eligibility

The Alliance provides the following ways to verify a member's eligibility:

- Visit the Alliance website and log onto the Provider Portal at **www.alamedaalliance.org**.
- Call the Alliance Provider Services Department at **1.510.747.4510** (Monday – Friday, 7:30 am – 5 pm).

Verifying Medi-Cal Beneficiary Eligibilities

To verify member eligibility and health plan enrollment for Medi-Cal beneficiaries, providers must access the Medi-Cal Beneficiary Eligibility Verification System.

This system includes:

- Point of Service (POS) Device. To inquire about purchasing a POS Device, please call:
  Medi-Cal
  Toll-Free: **1.800.427.1295**, press **3** for assistance
- Automated Eligibility Verification System (AEVS)
  Medi-Cal
  Toll-Free: **1.800.456.2387**
  www.medi-cal.ca.gov/mcwebpub/login.aspx

Eligibility Response Example

Eligibility Message: SUBSCRIBER LAST NAME: [SUBSCRIBER LAST NAME]. EVC #: [EVC NUMBER]. CNTY CODE: 01. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. HEALTH PLAN MEMBER: PHP-ALAMEDA ALLIANCE FOR HLTH: MEDICAL CALL (510)747-4500.	
Subscriber Name: [LAST NAME], [FIRST NAME] [MI]	**Subscriber ID:** [SUBSCRIBER ID]
Subscriber Birth Date: [DOB]	**Issue Date:** [ISSUE DATE]
Primary Aid Code: 60	**First Special Aid Code:**
Second Special Aid Code:	**Third Special Aid Code:**
Responsible County: 01-Alameda	**Medicare ID:** [MEDICARE ID]
Service Date: [SERVICE DATE]	**Trace Number/Eligibility Verification Confirmation Number:** [EVC NUMBER]

Nursing facilities must have a personal identification number (PIN) to access eligibility systems. Long-term care (LTC) facilities are given a PIN when they become certified Medi-Cal providers. If you do not have a PIN, please call Medi-Cal toll-free at **1.800.541.5555**, press **3** for assistance, and remain on the line.

POS and AEVS will inform the facility of the following:

- If the resident is eligible for Medi-Cal benefits on the date of service.
- If the resident is an Alliance member.
- If the resident is enrolled in an Alliance health network.
- The phone number of the resident's health network if the resident is enrolled in a health network.
- The resident's primary care physician (PCP) information if the resident is enrolled in a health network.
- If the resident has a share of cost (SOC) or an LTC SOC.
- If the resident's SOC or LTC SOC has been met.

Please Note: If the AEVS shows eligibility for the date of service but does not identify the resident as an Alliance member, the Alliance is not responsible for the resident's care.

Obtaining an Eligibility Printout

Checking eligibility through the POS device will enable the facility to obtain a printout detailing member eligibility information for the date of service. This printout can be used for documentation should a discrepancy arise regarding a resident's eligibility. It is highly recommended that this printout be maintained in the resident's file.

Medical, Ancillary, and Acute Care Services

If the member is enrolled in an Alliance health network, the member's PCP is responsible for arranging the provision of covered medical care services. In most health networks, the member must be referred by the PCP for services in order to receive reimbursement for services rendered (with the exception of emergency or family planning services).

Members with Medi-Cal Share of Cost (SOC)

Some Alliance members qualify for their Medi-Cal benefit with a monthly share of cost (SOC). Such members must meet a specified SOC for their medical care expenses before they can be certified to receive Medi-Cal or Alliance benefits. The monthly SOC is based on the member's monthly income. When a Medi-Cal beneficiary has an LTC aid code and a SOC, a nursing facility will subtract the SOC that is paid or obligated to be paid from the claim amount. The Alliance will pay the balance.

The Alliance assumes nursing facility residents in long-term care will meet the SOC on a monthly basis and are therefore presumed eligible at the beginning of each month. If a nursing facility has questions about a SOC and potential balance billing of the member, please check AEVS before billing the member.

Under the Johnson vs. Rank settlement, recipients may use their SOC to pay for necessary, non-covered medical services, remedial services, or items not covered under the Medi-Cal program.

A "medical service" is considered a non-covered benefit if either of the following is true:

- The medical service is rendered by a non-Medi-Cal provider; or
- The medical service falls into the category of services for which an authorization request must be submitted and approved before Medi-Cal will pay and either an authorization request is not submitted, or an authorization request is submitted and denied because the service is not considered medically necessary.

A current provider's order is necessary for medical services and must be put in the recipient's medical record at the facility. The order must be a part of the provider's plan of care. After a copy of the order and the bill are presented to the facility, the facility will deduct the cost from that month's share of cost and bill the Alliance for the remaining balance.

If you have any questions about the SOC process, please call the Alliance Long-Term Care (LTC) Department at **1.510.747.4516**.

Section 3. Authorization Process

Introduction to Authorization

All long-term care (LTC) nursing facilities are required to obtain authorization each time a member is accessing services.

Sub-acute or Skilled Care

The Alliance Utilization Management (UM) Department or the Alliance-delegated physician group's utilization management department is responsible for the authorization of skilled care services. For admission instructions, please view the Alliance Provider Manual online at **www.alamedaalliance.org/providers/alliance-provider-manual**. You can also call the Alliance Provider Services Department at **1.510.747.4510**.

Long-Term Care (LTC)

The Alliance Long-Term Care (LTC) Department is responsible for the management and authorization of services for LTC admissions in nursing facilities.

Authorization for admission is processed in accordance with the following Alliance guidelines:

- The Alliance request for authorization form replaces the California Department of Health Care Services (DHCS) Treatment Authorization Request (TAR) 20-1 form.

  To request a copy of the Long-Term Care (LTC) Authorization Request Form (ARF), please call or visit the Alliance website:

  Alliance Long-Term Care (LTC) Department
  Phone Number: **1.510.747.4516**
  www.alamedaalliance.org

The Alliance uses the DHCS Medi-Cal skilled nursing criteria to determine the appropriateness of admissions and continued stay (Title 22 §51335 and §51003).

Continuity of Care

Effective Sunday, January 1, 2023, DHCS transitioned the fee-for-service (FFS) Medi-Cal LTC benefit to a managed care benefit.

A beneficiary who is an LTC resident of a nursing facility prior to enrollment in the Alliance will not be required to change nursing facilities if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and the Alliance agree to appropriate rates. For questions, the nursing facility can call the Alliance Long-Care Department at **1.510.747.4516**.

For nursing facilities with residents who are assigned to the Alliance, existing approved DHCS TARs will be honored for the duration of time in which the services are deemed medically necessary or a period of **6-12 months**.

Authorization of Medicare and Medi-Cal Services

The Alliance authorizes nursing facility services for members when medically necessary. Applicable levels of care are maintained and consistent with policies established by the Centers for Medicare and Medicaid Services (CMS) and with the criteria for authorizing Medi-Cal services specified in Title 22 CCR §51003.

Initial LTC Authorization and Reauthorization Process

The request for authorization or reauthorization can be submitted when:

- An Alliance member is a new admission to the nursing facility or a returning resident.
- The member has exhausted Medicare benefits and will remain in the nursing facility for continued care.
- Medicare benefits have been denied.
- The member has been readmitted from an acute care hospital and did not return on **day number eight (8)**.
- The member has returned from an approved leave of absence but the return date is beyond the approved time period allowed.
- A resident becomes an Alliance member while residing in the nursing facility, as either a new Medi-Cal beneficiary or an existing Medi-Cal beneficiary, whose county of eligibility has changed from another county to Alameda County and has chosen or is assigned as an Alliance member.

Authorizations and reauthorizations for LTC admissions are valid for up to **one (1) year**. Authorization numbers should be retained and submitted on the nursing facility's claims submission.

Initial Authorization

Nursing facilities must submit appropriate documentation to support the nursing facility admission within **24 hours** of the member's admission. If the authorization request is not submitted to the Alliance LTC team within **21 calendar days** of the admission, the nursing facility is subject to denial.

For initial authorization, documentation should include:

- Verification of Alliance eligibility
- Completed LTC RRF and the physician order with the physician's signature
- Documentation to support the level of care requested (i.e. Interdisciplinary Team Evaluation, MDS 3.0, etc.)

The LTC RRF must be submitted to the Alliance within **21 calendar days** of the member's admission. The Alliance LTC nurse specialist will notify the facility of the authorization decision within the regulatory requirement as defined in the Alliance policy. If the member meets admission criteria, the Alliance LTC nurse specialist will contact the nursing facility with the assigned authorization number. If the member does not meet the admission criteria, the nursing facility will receive a denial notification and will not be paid from the date of the admission.

Nursing facilities are responsible for notifying the Alliance LTC nurse specialist if the **21-day** limit expires. If the RRF is not submitted to the Alliance within **21 calendar days** of the admission, the nursing facility is subject to denial or reduction of payment for days beyond the **21st day** of admission.

Please see **Section 7: Appendix** for a general sample of the Long-Term Care (LTC) Referral Request Form (RRF).

Reauthorization

For reauthorization, documentation should include:

- Verification of Alliance eligibility
- Completed LTC RRF and the physician order with the physician's signature
- Documentation to support the level of care requested (i.e., Interdisciplinary Team Evaluation, MDS 3.0, etc.)

A reauthorization request must be submitted to the Alliance prior to the expiration date of the active authorization (and up to **60 days** prior to the active authorization expiration date). Nursing facilities are responsible for notifying the LTC team before the authorization expires. If the request for reauthorization is not submitted to the Alliance prior to the expiration, the nursing facility is subject to denial or reduction of payment for days beyond the expiration date. The same Medi-Cal timeframes apply.

Prior Authorization Request – Determination Turnaround Times	
Non-Urgent Requests	Within 5-14 business days of receipt.
Urgent Requests	Within 72 hours of receipt.
Urgent Concurrent Decisions	Within 24 hours of notification, if clinical is available; 72 hours if clinical is requested.

Changes in a Member's Condition and Discharge

A nursing facility may modify its care of a member or discharge the member if the nursing facility determines that the following specified circumstances are present:

- The nursing facility is no longer capable of meeting the member's health care needs.
- The member's health has improved sufficiently so that they no longer need nursing facility services.
- The member poses a risk to the health or safety of individuals in the nursing facility.

The Alliance requires documentation from the nursing facility to verify that the facility's care modification was made for the allowable reasons noted above. When these circumstances are present, the Alliance shall arrange and coordinate a discharge of the member and continue to pay the nursing facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate care setting.

The Alliance will also arrange and coordinate the discharge of a member if the Alliance determines that one (1), or more of the three (3) circumstances noted above are present, or if the facility does not meet the Alliance's network standards because of documented quality of care concerns.

Member's Transition to Skilled Care

If an LTC resident has a change in health status and requires skilled care services, the nursing facility must notify the assigned Alliance LTC nurse specialist of the transition of care within **24 hours** or by the next business day. The Nursing facility must not withhold medically necessary services pending authorization from the Alliance when the services are requested by a designated physician, or health care professional in lieu of emergency room transfers or acute care admissions. The Alliance or its delegate will provide post-service authorization for medically necessary services provided to members.

Bed Hold and Leave of Absence

As a covered benefit, the Alliance provides any bed hold or leave of absence that a nursing facility provides in accordance with the requirements of Title 22 California Code of Regulations, §72520.

Bed Hold Guidelines

Bed hold requests are required when a member's stay is being covered by Medicare or a Medicare health plan and the member is admitted to an acute care hospital with an anticipated length of stay of not greater than **seven (7) days**.

Nursing facilities are required to hold a bed vacant when requested by the member or member's responsible party unless notified that the member requires more than **seven (7) days** of acute hospitalization. A physician's order for hospitalization and bed hold must be in place.

The member must be in the facility at least **24 hours** prior to the start of the bed hold. If the LTC nursing facility is aware that the member requires greater than **seven (7) days** of acute hospitalization, the facility is not required to hold the bed and cannot bill the Alliance for any remaining bed hold days. Bed hold payments will not be made when a member is discharged from the facility that is receiving payment for a bed hold within **24 hours** from their return from an acute care hospital. Bed hold payment terminates on the member's day of death.

There are no limits to the number of bed-hold episodes. However, the member must remain at the facility for at least **24 hours** prior to the start of the next bed-hold period. The date of departure counts as **day one (1)** of the bed hold. The day of return will be counted as a day of acute care. The member is considered discharged if not returned to the facility on **day eight (8)** after an acute care hospital admission.

A completed LTC RRF marked "bed hold" must be submitted within **21 days** of the final day of the bed hold or before submitting a claim for reimbursement. The Alliance will issue a response within **five (5) business days** of receipt of a completed request.

Leave of Absence Guidelines

In addition to acute hospitalization bed holds, a leave of absence of up to **18 days** may be prescribed by a PCP for a visit with relatives or friends and outpatient diagnostic or treatment services at an acute hospital. For the physical and mental well-being of a member, **12 days** of leave per year may also be approved. A provision for the leave of absence including dates, intended destination, and reason for the leave must be documented in the member's plan of care.

The request for a leave of absence must be submitted on an LTC RRF marked "leave of absence" **two (2) weeks** prior to the leave. The Alliance will issue a response within **five (5) business days** of receipt of a completed request. If a member voluntarily leaves the facility without an approved leave of absence request or fails to return by midnight on the scheduled date of return, the member is considered "AWOL" and a new LTC RRF is required when the member returns.

Section 4. Claims and Payment

Claims Submission

This section provides an overview of the Alliance claim policies. Additional information can be found in your Alliance Provider Manual or online at **www.alamedaalliance.org**. Providers can check the status of their claim submissions by logging into the secure provider portal on the Alliance website.

For questions regarding claims submissions, please call:

Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**

Long-term care (LTC) providers rendering services to Alliance members must follow all Medi-Cal rules and regulations for billing. Claims may be submitted by mail or electronically.

For paper claims, please mail them to:

Alameda Alliance for Health
Attn: Claims Department
PO Box 2460
Alameda, CA 94501-0460

Electronic Data Interchange (EDI) Services

The Alliance offers providers the speed, convenience, and lower administrative costs of electronic claims filing, also known as Electronic Data Interchange (EDI). The claims are sent in real-time. Claims that require attachments may not be sent electronically; they must be submitted on the appropriate claim forms with the attachments.

Providers interested in submitting claims electronically can contact:

Alliance Electronic Data Interchange (EDI) Department
Phone Number: **1.510.373.5757**
Email: **edisupport@alamedaalliance.org**

To submit claims electronically, please complete the Electronic Data Interface (EDI) Enrollment Form and Trading Partner Agreement. To receive payment or remittance advice statements electronically, please enroll in Electronic Funds Transfer (EFT). To access enrollment forms, please visit **www.alamedaalliance.org/providers/provider-forms**.

If you have questions about the claim submission process, billing codes, or to sign up, please contact:

Alliance Provider Services Department
Monday - Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

Claims Billing Process

All LTC providers rendering services to Alliance members must submit claims using the Institutional Provider Claim Form (UB-04). When submitting a claim, please be sure to include all required data elements in order to ensure timely payment. To be processed, an authorization number must be included on the claim form and the claim must match the authorization. An initial claim submission must occur within **six (6) months** from the date of service. Providers should follow all Medi-Cal rules for billing. To access the UB-04 Form with field-by-field instructions please view the Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual at: **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf**.

LTC Code and Claim Form Conversion: LTC Accommodation Code to Revenue Code, Value Code, and Value Code Amount Crosswalk

In accordance with the California Department of Health Care Services (DHCS), the Alliance requires all admissions under the custodial level of care to have an appropriate DHCS LTC Aid Code. The DHCS LTC Custodial Aid Codes are 13, 23, 53, and 63.

There are additional instructions for submitting Custodial Care Accommodation Codes based on the following Medi-Cal guidelines. Please use the codes below for services effective January 1, 2023 (for custodial care only). Additional code types may be added at a later date.

Accommodation Code	Accommodation Code Description	Rev Code	Value Code	Value Code Amount
01	NF-B Regular, (Distinct Part)	0101	24	01
01	NF-B Regular (Free-standing)	0101	24	07
21	NF-A Regular	0101	24	21
02	NF-B Regular, Leave of Absence, Non-DD Patient (Distinct Part)	0180	24	02
02	NF-B Regular, Leave Days, Non-DD Patient (Free-standing)	0180	24	08
22	NF-A Regular, Leave of Absence, Non-DD Patient	0180	24	22
02	NF-B Regular, Bed Hold, Non-DD Patient (Distinct Part)	0185	24	02
02	NF-B Regular, Bed Hold, Non-DD Patient (Free-standing)	0185	24	08
22	NF-A Regular, Non-DD Patient, Bed Hold	0185	24	22

For additional information, please visit **www.alamedaalliance.org/providers/billing**.

Medicare Co-Insurance and Deductibles

The Alliance covers nursing facility Medicare co-insurance and deductibles. The Alliance does not require members to pay co-insurance or deductibles for nursing facility services.

For questions about co-insurance or deductibles related to nursing facility services, please contact:

Alliance Provider Services Department
Monday - Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

Claims Processing

The Alliance pays claims in accordance with regulatory timeliness guidelines. Clean claims will be paid within **45 working days** from the date of receipt. If your claims are paid, denied, contested, or adjusted, the Alliance will provide a clear and accurate written explanation of the specific reasons for the claim determination. You can access a remittance advice statement through our Provider Portal.

To sign up or log in to the Alliance Provider Portal, please visit **www.alamedaalliance.org**. For more information, please refer to the Alliance Provider Portal Instructions Guide on the home page of the portal.

If the claim you submitted is incomplete, or if the Alliance requires additional information, we will deny the claim and the provider will need to resubmit the claim with the missing information. Upon receipt of the resubmission, the Alliance will pay, deny, or adjust the claim from the date the resubmission was received by the Alliance in order to review and process your claim. Interest will be paid on all late claims as mandated by State law.

If billing discrepancies occur, the Alliance will make every attempt to resolve the discrepancy in a timely manner. The Alliance may require copies of medical records or other relevant information in order to resolve any discrepancies.

Corrected Claims

If a claim is denied and the nursing facility is able to provide additional information to support payment, the nursing facility may resubmit the claim with the additional information within **365 days** from the last action date of the claim.

Claims Issues

If the nursing facility does not agree with a claim determination, the nursing facility may file a provider dispute resolution (PDR) request.

There are two (2) ways to submit a PDR request:

1. Electronically through the Alliance Provider Portal.
2. Completing and mailing the Provider Dispute Resolution (PDR) form. To access the form, please visit **www.alamedaalliance.org/providers/provider-forms**.

All disputes must be submitted within **365 days** from the last dated action by the plan, usually, the Remittance Advice date, and will be resolved within **45 business days** from the date of receipt.

Payment

The Alliance is required to reimburse institutional providers in accordance with the prompt payment provisions provided by the California Department of Health Care Services (DHCS), including the ability to accept and pay electronic claims.

As a reminder, upon entering into a contract with the Alliance to provide services for Alliance members, all providers agree to accept Alliance payment(s) as payment in full with no right to seek additional payments from members. For payment of non-authorized services where the member is deemed responsible, Alliance staff will speak to the member and/or family regarding payment, as determined by Alliance policy and procedures.

Electronic Fund Transfer (EFT)

The Alliance offers an Electronic Funds Transfer (EFT) option to all contracted providers. Providers who enroll in EFT will have fee-for-service (FFS) payments deposited directly into their bank account.

For a full description of accessing the EFT process, please call the Alliance Provider Services Department at **1.510.747.4510**. To enroll in EFT, providers must complete the Electronic Funds Transfer (EFT) Form available at **www.alamedaalliance.org/providers/provider-forms**.

Reporting Fraud, Waste, and Abuse (FWA)

Any potential issues related to Medicare or Medi-Cal fraud, waste, or abuse (FWA) should be reported.

Please report it immediately by using one of the following methods:

- Call the Alliance Compliance Department Hotline: **1.844.587.0810**
- Email the Alliance Compliance Department: **compliance@alamedaalliance.org**
- Visit the Alliance website: **www.alamedaalliance.ethicspoint.com**
- Call the Medi-Cal Fraud and Abuse Hotline: **1.800.822.6222**

Section 5. Complaint Process

Long-term care (LTC) facilities may request a reconsideration of an Alliance decision using the appeal process on behalf of the member or the Provider Dispute Resolution (PDR) process.

Provider Dispute Resolution (PDR) Process for Claim Disputes for Contracted Providers

The Alliance Claims Department has an established process for the receipt and review of claims disputes from contracted providers. For additional information and to check the status of disputes, providers can contact the Alliance Provider Services Department at **1.510.747.4510**.

The Alliance will be able to accept electronic PDRs through the following **two (2)** ways:

1. The Alliance provider portal
2. Through a secured email

Providers can access the PDR form at **www.alamedaalliance.org/providers/provider-forms**.

The completed form must be attached to a secure email and sent to **distgrpdeptcompliancepdr@alamedaalliance.org**.

Definition of a Claim Dispute: A claim dispute is a provider's written notice to the Alliance challenging, appealing, or requesting reconsideration of a claim (or a group of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested.

Claim disputes also include situations where a provider is seeking resolution of a billing determination or other contract dispute or is disputing a request for reimbursement of an overpayment of a claim.

Required Information: At a minimum, each claim dispute must include the provider's name, provider's contact information, a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.

How to Request a PDR: Claim disputes can be submitted electronically through the Alliance provider portal or by mail to:

Alameda Alliance for Health
Attn: Claims Department – Provider Dispute Resolution (PDR)
PO Box 2460
Alameda, CA 94501-4506

Phone Number: **1.510.747.4530**

Time Period for Submission of Claim Disputes: Claim disputes must be received by the Alliance within **365 days** after the last date of the action that led to the dispute. Claim disputes that do not include all the required information as described above may be returned for completion. An amended dispute that includes the missing information must be submitted to the Claims Department within **30 working days** of a returned dispute.

Acknowledgment of Claim Disputes: The Alliance Claims Department acknowledges receipt of all claim disputes from contracted providers in the following manner:

- Electronic disputes are acknowledged within **two (2) working days** of the date of receipt.
- Paper disputes are acknowledged within **15 working days** of the date of receipt.

Instructions for Filing Substantially Similar Claim Disputes: Substantially similar multiple claims, billing, or contractual disputes may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

- Please sort disputes by similar issues
- Provide a cover sheet for each batch
- Number each cover sheet

Please include a cover letter for the entire submission describing each dispute with references to the numbered cover sheets.

Time Period for Resolution and Written Determination of a Claim Dispute: Within **45 working days** from the date of receipt of the dispute or the amended dispute, the Alliance Claims Department will issue a written determination that will state the reasons for the Alliance's decision. If the dispute is determined in whole or in part in favor of the provider, the Alliance pays any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within **five (5) working days** of the issuance of the written determination.

Levels of Complaint Processing

The Alliance offers the following ways to submit a complaint or concern:

- Member grievances, or grievances filed on behalf of the member
- Member appeals, or provider appeals on behalf of the member
- Provider complaints resolution (administrative/contract issues)
- Provider Dispute Resolution (PDR) (payment/claims related)

Complaints relating to member care are determined by the member or the member's physician and based on the urgency of the service.

All complaints will be resolved within the following timeframe from the date of receipt:

- Standard (routine) complaints – Within **30 calendar days**
- Expedited (urgent) complaints – Within **72 hours**

Complaints related to administrative, contractual, or claims processing are not considered urgent and will be resolved within **30 calendar days** from receipt of the request.

Member Grievances

Member grievances are defined as any expression (oral or written) of dissatisfaction related to care and/or services provided to a member. This includes any complaint, dispute, requests for reconsideration, or appeals made by a member. Member grievances or grievances filed on behalf of the member can be submitted by calling the Alliance Member Services Department at **1.510.747.4567**. You can also submit a completed Member Grievance Form on the Alliance website at **www.alamedaalliance.org**.

Member Appeals

For authorization of service requests received and the determination made to deny or modify the request, the member or member's authorized representative, primary care provider (PCP), and requesting provider will receive written communication of the determination or Notice of Action (NOA). Upon receipt of the NOA, the member/member's authorized representative or nursing facility on behalf of the member may request reconsideration (appeal) of a level of care decision to deny or modify a request for services.

Appeals must be submitted in writing to the Alliance within **90 calendar days** from the date of receipt of the NOA and include all of the following:

- A letter clearly stating the request
- Relevant material such as clinical documentation
- A copy of the NOA received

Please mail the appeal with all enclosures to:

Alameda Alliance for Health
Attn: Member Services Department
PO Box 2818
Alameda, CA 94501-0818

Grievance and Appeals Process

The Alliance will acknowledge receipt of the complaint within **five (5) business days**. The Alliance Grievance and Appeals Department will review the request and will prepare documents for review with an Alliance Medical Director who was not involved in the initial decision, or the department involved in the decision. If the information provided in the written complaint is not adequate, the Alliance Grievance and Appeals Department will request missing or additional information in writing.

All complaints will be resolved within the following timeframe from the date of receipt:

- Standard (routine) complaints – Within **30 calendar days**
- Expedited (urgent) complaints – Within **72 hours**

Details of the resolution, including the date the resolution will be/has been implemented are communicated in writing to the member and the provider. If a resolution of the complaint is anticipated to exceed **30 calendar days** from the date of receipt, because of the need for a detailed investigation, this delay and the anticipated date for resolution will be communicated in writing to the member and the provider.

Provider Complaint Resolution

The Alliance will make every effort to assist you in the resolution of complaints or problems encountered while providing services to our members.

For assistance, please contact your Provider Relations representative or contact:

Alliance Provider Services Department
Monday - Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

The Alliance Provider Relations staff will confer with other departments as necessary to respond to your complaint. For a grievance, complaint, or appeal related to medical necessity, you must first file an appeal as described above.

For administrative issues (or if there is dissatisfaction with the appeal decision of a denial related to medical necessity) you may file a provider complaint. Examples of administrative issues include clarification of the authorization process, billing process, or provider issues. Any question or concern that suggests issues that are not administrative in nature will be routed to the appropriate Alliance department for review. Potential quality of care issues will be forwarded to the Alliance Grievance and Appeals Department for review by a clinical staff person.

For issues related to claims, you must first follow the claims Provider Dispute Resolution process outlined below. If you are dissatisfied with the claim's resubmission decision or denial, a complaint may be filed.

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

- Full provider name and identification number (i.e., NPI).
- Provider contact information, including address, phone number, and fax number of the provider's designated contact person.
- An explanation of the complaint or issue, including any relevant attachments, documentation, and supplemental information.

If the complaint involves a service provided to an Alliance member, please include the member's full name, Alliance member ID number, and date of service.

Provider Dispute Resolution (PDR)

If a nursing facility claim is denied or modified and it does not agree (disputes) with the claim decision, the nursing facility may submit a provider dispute to request that the Alliance reconsider the determination. The Alliance Claims Department will be able to assist with starting a formal appeal or the nursing facility can fill out the Provider Dispute Resolution (PDR) Request Form. To access the form, please visit **www.alamedaalliance.org/providers/provider-forms**.

Please mail or fax the PDR Request Form to:

Alameda Alliance for Health
Attn: Claims Department – Provider Dispute Resolution (PDR)
PO Box 2460
Alameda, CA 94501-4506

Fax: **1.855.891.7173**

The Alliance will acknowledge receipt of the PDR request within the following days:

- Mailed PDR Request Forms – **15 business days**
- Faxed PDR Request Forms – **Two (2) business days**

The Alliance Claims Department or Provider Dispute Resolution Unit will review the request and will prepare documents for review using contract and regulatory requirements. For PDRs based on denial due to the lack of medical necessity, the dispute will be reviewed with a health care professional or the Alliance Medical Director who was not involved in the initial decision, or the department involved in the decision.

A provider dispute must contain a clear identification of the disputed item, including the date of service, full Alliance member name, Alliance member ID number, and a clear explanation of the basis upon which the provider believes the payment or action is incorrect. Please be sure to include the same number assigned to the original claim. Disputes that do not include all of the required information as described above may be returned for completion.

If the information provided in the written complaint is not adequate, the Alliance will request missing or additional information in writing. All disputes will be resolved within **45 business days** from the date of receipt. Details of the resolution are communicated in writing to the provider.

For questions or more information, please contact your Provider Relations representative or contact:

Alliance Provider Services Department
Monday - Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

We Are Here to Help You

We hope that you have found the information and resources in this guide to be useful and helpful.

If you have any questions or concerns, please contact:

Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: **providerservices@alamedaalliance.org**

Thank you for joining the Alliance provider network! We look forward to continued partnership with you to provide quality and affordable healthcare. Together, we are creating a healthier community for all.

Section 6. Key Contacts

RESOURCE	CONTACT
Alameda Alliance for Health (Alliance)	
Alliance Main Number	Phone Number: **1.510.747.4500**
Case and Disease Management (CMDM)	Phone Number: **1.877.251.9612** Fax: **1.510.747.4130**
Claims Department	Paper claims can be submitted to: Alameda Alliance for Health Attn: Claims Department PO Box 2460 Alameda, CA 94501-0460 Electronic claim files can be submitted to the Alliance Electronic Data Interchange (EDI) Department.
Long-Term Care Department *Including Authorizations – Nursing Facility (LTC)*	Phone Number: **1.510.747.4516** *Authorizations – Nursing Facility (LTC):* Fax: **1.510.747.4191**
Member Services Department	Phone Number: **1.510.747.4567** Toll-Free: **1.877.932.2738** People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
Provider Services Department	Phone Number: **1.510.747.4510**
Utilization Management (UM) Department *Including Authorizations – Nursing Facility (Skilled)*	Phone Number: **1.510.747.4540** Disputes Fax: **1.855.891.7174** Routine/Urgent Requests Fax: **1.855.891.7174** *Authorizations – Nursing Facility (Skilled):* Fax: **1.510.747.4130**
Interpreter Services	
CyraCom	Phone Number: **1.510.809.3986**
Prescheduled Interpreter Requests	Fax: **1.855.891.9167**
Non-Emergent Medical Transportation (NEMT)	
Alliance Transportation Services	Toll-Free: **1.855.891.7171** Fax: **1.877.457.3352**

Section 7. Appendix

Long-Term Care – Request for Referral Form (RRF) General Sample

SECTION 1: REFERRAL INFORMATION

Date of Referral (MM/DD/YYYY): 1/1/2023

Referral Source *(please select only one (1)*:

☐ **Internal to the Alliance** *(please select only one (1)*:

- ☐ Behavioral Health
- ☐ Case Management
- ☐ Community Supports
- ☐ Customer Solution Center
- ☐ Enhanced Care Management
- ☐ Social Worker
- ☒ Utilization Management
- ☐ Other: _____

☐ **External from the Alliance** *(please select only one (1)*:

- ☐ Community-Based Adult Services (CBAS)
- ☐ Community-Based Organization (CBO)
- ☐ Hospital
- ☐ Member/Family/Caregiver
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Participating Physician Group (PPG)/ Independent Physician Association (IPA)
- ☐ Pharmacy
- ☐ Provider
- ☐ Skilled Nursing Facility (SNF)
- ☐ Vendor
- ☐ Other: _____

Referred By: UM RN Reviewer Phone Number (Ext.): XXX

Member is currently:

- ☐ In a nursing facility under skilled care
- ☒ In an acute hospital
- ☐ N/A

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SECTION 2: MEMBER INFORMATION

MEMBER INFORMATION

Last Name: Doe
First Name: John
Date of Birth (MM/DD/YYYY): 03/23/1950
Age: 70
Language: Tagalog
Gender: ☒ Male ☐ Female
Alliance Member ID #: XXXXXXXX
CIN: XXXXXXX
Address: 123 Happy Road
City: Alameda
State: CA
Zip Code: 95515
Phone Number: XXX-XXX-XXXX
☐ Home ☐ Cell
Line of Business: ☐ Group Care ☒ Medi-Call

AUTHORIZED REPRESENTATIVE (AOR) INFORMATION

Last Name:
First Name:
Phone Number:
Consent to speak to AOR: ☐ Yes ☐ No
Primary Language:
Request for interpreter: ☐ Yes ☐ No

SECTION 3: CLINICAL INFORMATION

Diagnosis: Residual effects of current CVA
Member currently enrolled in an Alliance Case Management Program: ☐ Yes ☐ No
Case Manager Last Name: Nightingale
Case Manager First Name: Florence
Phone Number (Ext.): XXX-XXX-XXXX ext. XXX
Fax Number: XXX-XXX-XXXX

Member has recently been admitted to *(please select all that apply)*:

☐ Emergency room
☒ Hospital
☐ SNF

Most Recent Discharge Date (MM/DD/YYYY): 1/1/2023

Member's General Condition *(please select all that apply)*:

☐ Ambulatory
☒ Ambulatory with assistance
☐ Confined to a bed
☐ Confined to a wheelchair
☒ Incontinent
☐ Maximum assistance with all ADLs/IADLs
☒ Other (specify): Aspiration precaution/Pureed diet

Summary of member issue(s), need(s), and concern(s):

Member with new baseline functionality and needs assistance with all ADLs. Residual effects of current CVA episode now on pureed diet and swallowing precautions. Member also noted to have Stage I pressure ulcer bilateral hip, currently being treated with Duoderm. Position monitoring and turn q2 hours. Also on pressure reducing mattress and wheelchair cushion. Member uses hearing aid to communicate and primary language is Tagalog but understands English.

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SECTION 4: REQUESTED SERVICE(S)

Requested Managed Long-Term Services and Supports (MLTSS) Services *(please select only one (1))*:

- ☐ Long-Term Care (LTC) Nursing Facility *(please select all that apply **and** complete **Section 1: Referral Information** on **page 1**)*:
  - ☐ Be at home, at risk in the community
  - ☐ Needs 24-hour care/assistance with ADLs
  - ☐ Other (specify): _____
- ☐ Community-Based Adult Services (CBAS) *(please see below **and** complete **Section 1: Referral Information** on **page 1**)*:
  *Member must be 18 years or older, be an Alliance Medi-Cal member, **and*** have one (1) or more of the following:
  - ☐ At risk for nursing facility placement
  - ☐ Developmental disability
  - ☐ Mild cognitive disorder such as dementia ***and*** need assistance or supervision with two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication, management, or hygiene
  - ☐ Mild to severe cognitive disorder
  - ☐ Organic, acquired, or traumatic brain injury, and or chronic mental disorder ***and*** needs assistance with activities of daily living

Reason for CBAS Referral:

- ☐ Increase in days
- ☐ Initial request
- ☐ Request to change CBAS center
- ☐ Other (specify): _____