ALAMEDA Alliance FOR HEALTH

# Provider Manual

## Alameda Alliance for Health
## Medi-Cal & Alliance Group Care

October 2024

# Table of Contents

# Part 1. Alliance Services (PS)

## Section 1: Introduction (PS)

### Welcome to Alameda Alliance for Health (Alliance) (PS)

Thank you for joining the Alameda Alliance for Health (Alliance) provider network! This manual is intended to provide you with the information and requirements needed to navigate our health plan and to assist you with offering the best possible care to our Alliance members.

#### *ABOUT THE ALLIANCE*

The Alliance is a public, not-for-profit health plan offering high-quality managed care to Alameda County residents. We offer two (2) lines of business, Medi-Cal and the In-Home Supportive Services (IHSS) program, also known as Alliance Group Care.

#### *OUR MISSION, VISION, AND VALUES*

**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.

**Vision**

The vision of the Alliance is that all residents of Alameda County will achieve optimal health and well-being at every stage of life.

**Values (TRACK)**

- **Teamwork**: We participate actively, support each other, develop local talent, and interact as one team.
- **Respect**: We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.
- **Accountability**: We work to create and maintain efficient processes and systems that minimize barriers, maximize access and sustain high quality.
- **Commitment & Compassion**: We are empathic and care for the communities we serve including our members, providers, community partners and staff.
- **Knowledge & Innovation**: We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

## The Provider Manual (PS)

This Provider Manual describes your responsibilities to our members as a provider and is intended as a resource to help you provide them with the best possible care.

The Alliance requires that contracted practitioners, medical groups, providers, hospitals, ancillary providers, and other non-hospital facilities, together referred to as "Provider" or "Providers," fulfill the relevant specified responsibilities described in this Provider Manual.

The Alliance Provider Manual is regularly updated and reviewed at least annually and made available to in-network and out-of-network providers on the Alliance website at **www.alamedaalliance.org**.

Starting in 2024, the Alliance Provider Manual will be presented for review to the Alliance Quality Improvement Health Equity Committee (QIHEC)

If you have any questions about the Alliance, our practices, or our members, please call our Alliance Provider Services Department at **1.510.747.4510**.

## Getting Involved (PS/Credentialing)

Provider involvement helps us improve services for our members and providers.

***WAYS TO PARTICIPATE:***

**Quality Improvement Health Equity Committee (QIHEC): The** QIHEC meets at least quarterly. The Alliance Providers are encouraged to participate in the QIHEC and its peer subcommittees. QIHEC and other subcommittee members are paid a stipend. For more information, please call the Alliance Peer Review and Credentialing Department at **1.510.747.4522**.

**Credentialing Committee (CC): The** CC meets monthly to review new provider applications, re-credentialing information. For more information, please call the Alliance Peer Review and Credentialing Department at **1.510.747.4522**.

**Peer Review Committee (PRC): The** PRC reviews quality issues on contracted providers on an as needed basis. For more information, please call the Alliance Peer Review and Credentialing Department at **1.510.747.4522**.

**The Alliance Provider Manual:** The Alliance communicates with providers through this manual and periodic updates. Provider suggestions have been incorporated into this manual. Feedback is always helpful in keeping the manual as up to date as possible. To share any ideas or comments, please call the Alliance Provider Services Department at **1.510.747.4510**.

**The Alliance Provider Updates Bulletin:** The Alliance periodically distributes provider letters, newsletters, memos, and updates with additional information to keep you informed. If you haven't received these provider communications, or if you have ideas for topics that you would like to see covered, please call the Alliance Provider Services

Department at **1.510.747.4510**.

**Provider Training Sessions:** The Alliance conducts training sessions throughout the year for providers and their staff. If you or your staff are interested, please call the Alliance Provider Services Department at **1.510.747.4510**.

**Pharmacy & Therapeutics (P&T) Committee**: The P&T Committee meets quarterly to review the drug formulary and make changes to the authorization review criteria. For more information, please call the Alliance Pharmacy Services Department at **1.510.747.4541**.

| DEPARTMENT | PHONE NUMBER | ADDRESS | WEBSITE |
|---|---|---|---|
| Alameda Alliance for Health | Phone Number: **1.510.747.4500**<br>Toll-Free: **1.877.371.2222** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Behavioral Health Care Services: | Toll-Free: **1.855.856.0577** | 1240 South Loop Rd Alameda, CA 94502, | **www.alamedaalliance.org** |
| Alliance Case & Disease Management (CMDM) | Toll-Free: **1.877.251.9612** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Compliance Hotline | Toll-Free: **1.844.587.0810** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Automated Eligibility Line | Phone Number: **1.510.747.4505** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Grievance and Appeals (G&A) Department | Phone Number: **1.510.747.4567**<br>Fax: **1.855.891.7258** | 1240 South Loop Road Alameda, CA 94502 | To file a grievance online, please visit: **www.alamedaalliance.org** |
| Alliance Health Education Program | Phone Number: **1.510.747.4577**<br>Fax: **1.877.813.5151** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org/live-healthy**<br>Email: **livehealthy@alamedaalliance.org** |
| Alliance Long-Term Care (LTC) Department | Phone Number: **1.510.747.4516**<br>Fax: **1.510.747.4191** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org**<br>Email: **LTCHCS@Alamedaalliance.org** |

| DEPARTMENT | PHONE NUMBER | ADDRESS | WEBSITE |
|---|---|---|---|
| Alliance Member Services Department | Phone Number: **1.510.747.4567**<br>Toll-Free: **1.877.932.2738**<br>People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org/contact-us**<br>Email: **memberservices@alamedaalliance.org** |
| Alliance Pharmacy Services Department | Phone Number: **1.510.747.4541**<br>24-Hour Service: **1.855.508.1713** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Provider Services Department | Phone Number: **1.510.747.4510**<br>Fax: **1.855.891.7257** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedalliance.org/providers**<br>Email: **providerservices@alamedaalliance.org** |
| Alliance Utilization Management & Authorizations | Phone Number: **1.510.747.4540**<br>Prior Authorization Fax: **1.855.891.7174**<br>Concurrent Review:<br>• Admission Fax: **1.855.313.6306**<br>• Clinical Information Fax: **1.855.891.7409** | 1240 South Loop Road Alameda, CA 94502 | **www.alamedaalliance.org** |
| Alliance Cultural and | 24-Hour Interpreter | | **www.alamedaalliance.org/providers/pr** |

| DEPARTMENT | PHONE NUMBER | ADDRESS | WEBSITE |
|---|---|---|---|
| Linguistic Services | Hotline (for interpreters by phone*)**1.510.809.3986** | | **ovider-resources/language-access**<br>Email:<br>**interpreters@alamedaalliance.org** |
| ACCESS Program Alameda County Behavioral Health Care Services (Medi-Cal) | Toll-Free:<br>**1.800.491.9099** | 2000 Embarcadero Cove, Suite 400 Oakland, CA 94606 | **www.acbhcs.org** |
| Advice Nurse Line | Medi-Cal Members:<br>**1.888.433.1876**<br>Group Care Members:<br>**1.855.383.7873** | | |
| Clinical Laboratory Outpatient Services: Quest Diagnostics | Toll-Free:<br>**1.800.288.8008** | | **www.questdiagnostics.com** |
| Dental Services (Group Care): Public Authority | Phone Number:<br>**1.510.577.3551** | | **www.acgov.org** |
| Dental Services (Medi-Cal): Medi-Cal Dental Program | Toll-Free:<br>**1.800.322.6384**<br>People with speaking impairments (TTY):<br>**1.800.735.2922** | | https://dental.dhcs.ca.gov/ |
| Durable Medical Equipment Provider: California Home Medical Equipment (CHME) | Toll-Free:<br>**1.800.906.0626** | | **www.chme.org**<br>Email:<br>**aaquestions@chme.org** |
| Medi-Cal Rx administered by Magellan | Toll-Free:<br>**1.800.977.2273** | | **www.medi-calrx.dhcs.ca.gov** |

Questions? Call the Alliance Provider Services Department, Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.
Visit us online at **www.alamedaalliance.org**.

| DEPARTMENT | PHONE NUMBER | ADDRESS | WEBSITE |
|---|---|---|---|
| | TDD: **711** | | |
| Teladoc<br>Telehealth Provider | Toll-Free:<br>**1.800.TELADOC**<br>(**1.800.835.2362**) | | **www.alamedaalliance.org/members/teladoc** |
| Transportation Services | Toll-Free:<br>**1.866.791.4158** | | **www.alamedaalliance.org** |
| Vision Services (Group Care): Public Authority | Phone Number:<br>**1.510.577.3551** | | **www.acgov.org** |
| Vision Services (Medi-Cal): MARCH Vision | Toll-Free:<br>**1.844.336.2724** | | **www.marchvisioncare.com** |

*In-person interpreters are available for ASL and complex or highly sensitive appointments. For more information, please see “Requesting Interpreter Services” in Section 14: Serving Your Diverse Population.

# Section 2: The Alliance Resources (PS)

## Alliance Provider Services Department (PS)

The Alliance Provider Services Department is your primary link to the Alliance. A quick phone call to an Alliance Provider Relations representative can answer many of your questions about our policies and procedures.

The Alliance Provider Services Department provides information and support to all Alliance network providers about:

- Access
- Alliance promotional materials
- Authorization status trainings
- Benefits
- Claims/billing status
- Contract issues
- Interpreter services
- Member eligibility
- Office address, and provider directory changes
- PCP assignment
- Peer review
- Provider billing accounts
- Provider bulletins
- Provider credentialing, and re-credentialing
- Provider discharges
- Provider network inquires
- Provider portal access
- Site reviews
- Transportation services

## Alliance Member Services Department (MS)

The Alliance Member Services Department helps manage member needs and concerns. The Alliance Member Services Department Call Center is specifically for members and member-related issues.

If a member has a question about their care or coverage, please encourage them to call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
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**

The Alliance Member Services Department can assist with:

- Changing a member's assigned primary care provider (PCP)
- Checking the status of a claim
- Checking the status of a prior authorization (PA) request
- Finding an in-network PCP, specialist, or behavioral health care provider
- Finding the location of an in-network pharmacy (For Alliance Group Care members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at www.medi-calrx.dhcs.ca.gov/home.)
- Health education materials and resources
- Interpreter services
- Learning more about plan benefits and services
- Mail order pharmacy information (For Alliance Group Care members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Reporting an issue or filing a grievance/appeal
- Requesting information on community resources
- Requesting a reimbursement for covered drugs or services (For Alliance Group Care members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- Requesting a replacement Alliance member ID card
- Scheduling transportation for covered services
- Updating a member's contact information (permanent contact information changes should be reported to the member's local social services agency by visiting **www.mybenefitscalwin.org**)
- Verifying a member's eligibility

The Alliance Member Services Department provides printed materials for members such as our Combined Evidence of Coverage (EOC) and health education resources. Members can also learn more about our services and their coverage on our website at **www.alamedaalliance.org**.

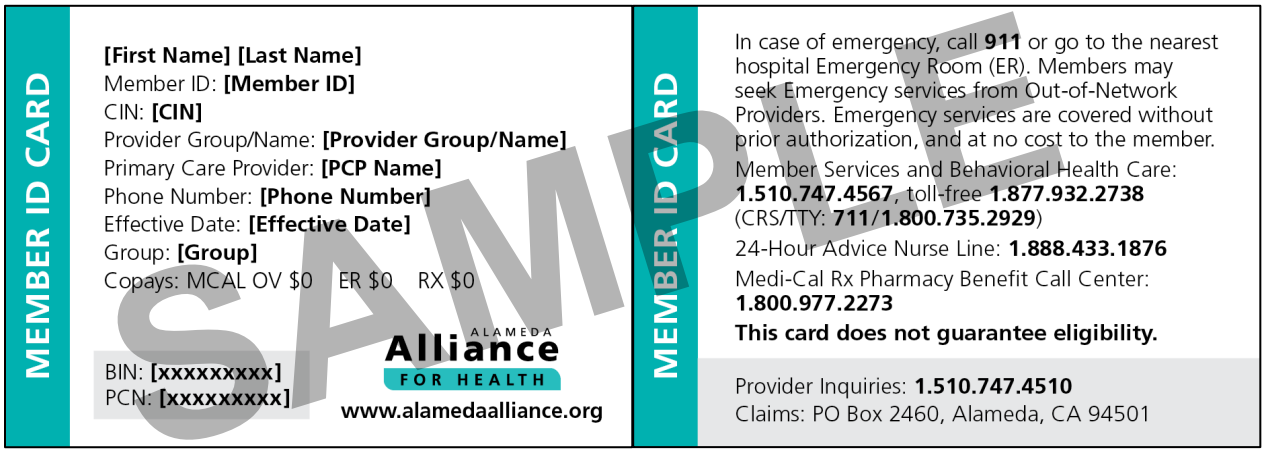
The Alliance Member Services Department can also help facilitate communication between members and providers.

For after-hours eligibility verification, please call the Alliance Eligibility Verification Line at **1.510.747.4505,** 24 hours a day, 7 days a week, or use the Online Provider Portal located through our website at **www.alamedaalliance.org**.

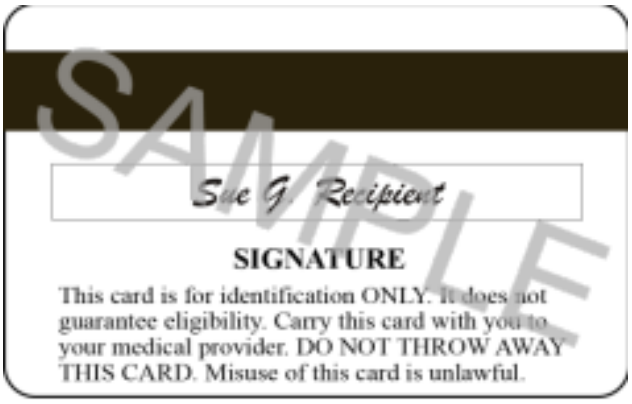
# Section 3: Eligibility and PCP Choice (PS)

## Identifying Alliance Members (PS)

***EACH ALLIANCE MEMBER IS ISSUED AN ALLIANCE MEMBER IDENTIFICATION (ID) CARD WITH A 9-DIGIT MEMBER NUMBER. PROVIDERS CAN ALSO USE THE MEMBER'S MEDI-CAL CLIENT IDENTIFICATION NUMBER (CIN) TO IDENTIFY MEMBERS WHO ARE MEDI-CAL BENEFICIARIES.ALLIANCE MEDI-CAL MEMBER ID CARD***




***MEDI-CAL BENEFITS IDENTIFICATION CARD (BIC)***


## Verifying Member Eligibility (PS)

Your office is responsible for verifying member eligibility and authorization at the time of service. We encourage you to save a copy of the eligibility results for your reference.

There are several ways to verify a member's eligibility:

- State's Automated Eligibility Verification System (AEVS) – For Alliance Medi-Cal members only):

  Toll-Free: **1.800.456.2387**
  **www.medi-cal.ca.gov/eligibility/Eligibility.aspx**

- Alliance Provider Services Department – For all Alliance members (Medi-Cal and Group Care):

  Monday – Friday, 7:30 am – 5 pm
  Phone Number: **1.510.747.4510**

- Alliance Automated Eligibility Verification Line:

  24 hours a day, 7 days a week
  Phone Number: **1.510.747.4505**

  Please have your National Provider Identifier (NPI) or Taxpayer Identification Number (TIN) available.

- Alliance Provider Portal:

  Accessed through **www.alamedaalliance.org**

## Provider Portal Instructions (PS)

***ONLINE PROVIDER PORTAL***

The Alliance offers contracted and non-contracted providers access to our interactive website.

Through this website, you can:

- Check claims status and remittance advice statements
- Submit/check authorization status
- Submit a Provider Dispute Request (PDR)
- Submit a behavioral health care treatment report and care coordination forms*)*
- Submit professional claims electronically (including secondary claims)
- Verify member eligibility
- View the Alliance medication formulary (For Group Care members only. For Alliance Medi-Cal members, please visit Medi-Cal Rx at **www.medi-calrx.dhcs.ca.gov/home**.)
- View the Alliance Provider Directory
- View your gap-and-care reports (PCP only)
- View your roster with assigned members (PCP only)

Information on the website is updated every 24 hours directly from our internal system.

To use the online provider portal, you must first obtain a provider account:

- Visit the Alliance website at **www.alamedaalliance.org**, select the Provider Portal link located at the top right banner, then select the "Create Account" link on the Provider Portal landing page.
- For assistance, please contact:

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

## Selecting a PCP (PS)

The Alliance encourages members to participate in their health care by selecting a PCP from the provider network. Members can find a list of PCPs in their Alliance Provider Directories or online at **www.alamedaalliance.org**.

Members can choose a physician who is taking new members from the list of internal medicine, general medicine, family practice, pediatrics, and OB-GYNs (women can choose an OB-GYN as their PCP). An Alliance Member Services representative can help members find a PCP who knows their language or culture, or who is close to where they live or work.

Members can also choose a county or community clinic that is part of the Alliance network as their PCP. All Federally Qualified Health Centers (FQHC) in Alameda County are part of the Alliance Network. Members can go to any FQHC for medical care even if it is not part of the Alliance network.

The Alliance will mail members a new ID card with their PCP's name and phone number within **10 business days** to confirm their PCP selection (automatic or voluntary).

Members may change their PCP by calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
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**

When a member does not select a PCP in their first month of enrollment, the Alliance will assign a PCP based on member age, language, geographic location, and PCP capacity. A member's choice overrides automatic selection, and a member who has been automatically assigned will be prompted to call the Alliance Member Services Department if they prefer to be assigned to a different PCP. If the member is in a long-term care (LTC) facility and/or enrolled in both Medi-Cal and Medicare, they do not have to select a PCP.

## Changing PCPs (PS)

The Alliance values member empowerment and encourages members to find an in-network provider accepting new patients with whom they can build a rewarding primary care relationship. Members can change their PCP for any reason and at any time by calling the Alliance Member Services Department at **1.510.747.4567**.

Changes will be effective on the first of the following month when the request is made. In some cases, a member may be added to a practice as long as the Alliance receives the assignment request before the **5th of the month**. If you have questions about a member's eligibility or assignment, please call the Alliance Provider Services Department at **1.510.747.4510**.

The Alliance Member Service Department will confirm the PCP reassignment and the effective date by sending a confirmation letter and a new Alliance member ID card with the new PCP's name and phone number to the member within **10 business days**.

If a PCP leaves their practice or is no longer able to see patients for any reason, the Alliance Member Services Department will notify any affected members as soon as possible and assist them in selecting another PCP.

# Section 4: Provider Compliance (PS)

The California Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) have established guidelines for the Medi-Cal managed care program and Group Care members. Providers should familiarize themselves with these guidelines to avoid sanctions, fines, or suspension of membership.

## Travel Time and Distance Standards (PS)

DHCS established Network Adequacy Standards to ensure adequate availability and accessibility of services to members. These standards include time and distance standards based on county population density.

For Alameda County, the following standards have been established based on provider type:

- **10 miles** or **30 minutes** from the member's residence for adult and pediatric PCPs, OB/GYN primary care, and pharmacies.
- **15 miles** or **30 minutes** from the member's residence for adult and pediatric specialty care, hospitals, and adult and pediatric mental health providers.

Alternative access standards may be approved by DHCS.

## Hours of Operation (PS)

Alliance contracted providers are required to ensure the office hours of operation are equally accessible to all patients. This includes all Alliance members as well as Medi-Cal fee-for-service (FFS) beneficiaries.

## Alliance Marketing Materials (C&O)

### *PROMOTIONAL MATERIALS*

If you are interested in obtaining brochures, newsletters, or promotional materials, please call the Alliance Provider Services Department at **1.510.747.4510**.

## Approved Medi-Cal Marketing Methods (C&O)

As a health care provider, you may:

- Actively encourage your Medi-Cal patients to seek out and receive information and enrollment material that will help them select a Medi-Cal health care plan for themselves and their families.
- Provide patients with the phone number of the outreach and enrollment or Member Services Departments of the plan(s) with which you are affiliated.

Provide patients with the toll-free phone number of the DHCS, Health Care Options (HCO) enrollment contractor (toll-free: **1.800.430.4263**) and inform them of locations and times when they may receive individual or group assistance about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information, activities, presentations, and problem-resolution functions.

- Tell your Medi-Cal patients the name of the health plan or plans with which you are affiliated.

## Discharging Members (PS)

The Alliance allows PCPs and specialists to request the discharge of assigned members. The Alliance will work with the member to choose another PCP or specialist who can best meet the member's needs.

### *HOW TO DISCHARGE A MEMBER*

1. Determine the reason for the proposed discharge. Under the Medical Services Agreement, PCPs may only request the discharge of a member if medical services can no longer be successfully provided for reasons other than medical conditions. Some acceptable reasons for discharge include: unruly behavior, threatening remarks, frequently missed appointments, fraud, etc. Document the reason(s) for discharge in the member's medical record. Requests to discharge a member due to medical conditions, frequent visits, or high cost of care will be denied.
2. Contact the Alliance Provider Services Department (or your Provider Relations representative) in writing to request a discharge. On the practice letterhead, please provide complete documentation regarding the nature of the problem(s) and reason(s) for the discharge. The Alliance Provider Services Department will review the request.
3. When a discharge request is granted, the Alliance Member Services Department will notify the member regarding the change in status and will work with the member to find a new PCP or specialist.
4. The PCP or specialist must maintain responsibility for the member's care until reassignment is complete. This responsibility includes giving the patient a **30-day** written notice of the discharge.

   The member discharge notice must state the following:

   - That the PCP will be available for emergencies and prescriptions for **30 days** or until a new PCP or specialist assignment is effective;
   - That the member should contact the Alliance Member Services Department for assistance with selecting a new PCP or specialist; and
   - That the PCP or specialist will make available the member's medical records to the member's new PCP or specialist upon request.

Additionally, a copy of the member discharge letter must be sent to the Alliance Provider Services Department to ensure appropriate follow-up and member assistance.

- If the PCP, specialist, or member is dissatisfied with the decision, the PCP, specialist, or member may file a grievance for further review.

## Provider Directory Changes (PS)

Keeping your information up-to-date and accurate is important to ensure our provider directory information is correct and that we maintain accurate information about your demographics.

Changes that should be reported include, but are not limited to, the following:

- Site name
- Site location (including suite numbers and floors)
- Phone and fax number(s)
- Hours of operation
- Accepting member status
- Member age limitations
- Languages spoken by office staff and providers

The Alliance requests that you notify us immediately of any updates that need to be made to the Alliance Provider Directory by calling the Alliance Provider Services Department at **1.510.747.4510**.

## Provider Data Requirements (274) (PS)

The Alliance is required to report multiple provider data elements for all contracted providers to DHCS monthly. The report is called a 274 and is a comprehensive and standardized file layout and protocol used by all Medi-Cal plans to submit provider network data to DHCS. The data will be used by DHCS for network assessments, data analytics, and other federal and state reporting requirements.

The preferred method to submit to the Alliance is through a file format called a Flat File. The Alliance can provide you with a Flat File template and help get you set up with how to send files electronically to allow providers to report required changes.

The required information includes, but is not limited to:

- Provider full name
- NPI
- Gender
- Date of birth
- Specialty
- Languages

- Provider license number
- DEA number
- Board certification
- Site NPI and tax ID of where the providers practice
- Site location of where the providers practice
- Hospital privileges
- Provider additions and terminations

# Part 2. Providing Services

## Section 5: Primary Care Provider (PCP) Roles and Responsibilities (PS)

It is the primary care provider (PCP) who acts as the primary case manager to all assigned members. This means the PCP must follow case management protocols as set forth in this section.

### PCP Services (PS)

#### *CARE MANAGEMENT PROTOCOL*

As a PCP in the Alliance network, we ask that you follow care management protocols as set forth in this manual for the following areas:

- Check the rosters posted on the provider portal monthly to know which members are assigned to you as their PCP.
- Coordinate and direct appropriate care for members by means of an initial diagnosis and treatment and obtain second opinions and consultation(s) with contracting specialists, as necessary.
- Coordinate member discharge planning and referral to long-term care (LTC) or other services with the hospital and the Alliance.
- Establish procedures to contact members when they miss appointments, require rescheduling for additional visits, or confirm referrals to a specialist for care.
- Follow-up on referrals made to specialists to assess the results of the care, medication regimen, and special treatment, and ensure continuous care.
- Provide a medical history and physical examination as appropriate:
    - For new members: Provide an Initial Health Appointment (IHA) within **120 calendar days** of the member's effective date of enrollment.
- Provide the specified scope of services to members.
- Refer, as necessary, certain medically necessary non-emergency hospital specialty services, and diagnostic testing.

## *OVERALL GOALS OF CARE MANAGEMENT*

The Alliance will assist our PCPs in achieving these overall case management goals:

- Coordinate care of members in order to achieve positive care results.
- Discourage inappropriate use of pharmacy and drug benefits.
- Facilitate patient understanding and use of disease prevention practices and early diagnostic services.
- Provide a structure for physicians to manage services by providing performance data on utilization, cost, and quality.
- Provide National Committee for Quality Assurance (NCQA)-compliant Case and Disease Management for members.
- Reduce, where appropriate, the use of emergency services as a source of nonemergency care.

## *ACCESS STANDARDS FOR PROVIDERS*

Please see below for a table detailing the required DHCS, DMHC, NCQA, and Alliance required response times:

| | |
|---|---|
| | |
| | |
| | |
| | |

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| **APPOINTMENT WAIT TIMES** | |
| **Appointment Type:** | **Appointment Within:** |
| Urgent Appointment that *does not* require PA | 48 Hours of the Request |
| Urgent Appointment that *requires* PA | 96 Hours of the Request |
| Non-Urgent **Primary Care** Appointment | 10 Business Days of the Request |

| | |
|---|---|
| **First Prenatal** Visit | 2 Weeks of the Request |
| Non-Urgent Appointment with a **Specialist** Physician | 15 Business Days of the Request |
| Non-Urgent Appointment with a **Behavioral Health** Provider | 10 Business Days of the Request |
| Non-Urgent Appointment with an **Ancillary Services** for the diagnosis or treatment of injury, illness, or other health conditions | 15 Business Days of the Request |

| ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES | |
|---|---|
| **Appointment Type:** | **Appointment Within:** |
| In-office wait time | **60 minutes** |
| Call return time | **1 business day** |
| Time to answer call | **10 minutes** |
| Telephone access – Provide coverage **24 hours a day, 7 days a week**. | |
| Telephone triage and screening – Wait time not to exceed **30 minutes**. | |
| Emergency instructions – Ensure proper emergency instructions. | |
| Language services – Provide interpreter services **24 hours a day, 7 days a week**. | |

***The DMHC Timely Access Standard is 15 Business days for Psychiatrist; however, to comply with NCQA accreditation standards of 10 Business days, Alliance uses the more stringent standards.**

**PA – Prior Authorization**

**Urgent Care:** Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

**Non-urgent Care:** Routine appointments for non-urgent conditions.

**Triage or Screening:** The assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage and determine the urgency of the member's need for care.

**Shortening or Extending Appointment Timeframes:** The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the Member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

### *INITIAL HEALTH APPOINTMENT (IHA)*

All new Alliance members must receive an Initial Health Appointment (IHA). The IHA consists of a history, a review of systems, a physical exam, and preventive services. For Medi-Cal members, this must be completed within **120 days** of enrollment. During site audits, a PCP's compliance with this standard will be assessed. On an on-going basis, the Alliance's Quality Improvement Department conducts a random audit to determine if all components of the IHA have been completed and whether the completion followed the guidelines.

The IHA should consist of an evaluation sufficient to enable the PCP to assess the acute, chronic, and preventive health needs of the member and assume responsibility for effective management of the member's health care service needs.

For children, the IHA must consist of the elements found in the most recent periodicity schedule recommended by the Bright Futures Guidelines/American Academy of Pediatrics (AAP). PCPs shall provide preventive health visits for all members under **21 years of age** for Early and Periodic Screening, Diagnostics, and Treatment services at times specified by the most recent AAP periodicity schedule. The IHA must bring members up to date with all currently recommended preventive services for the lower age nearest to the current age of the child.

**Codes that qualify for IHA:**

| Provider | CPT Codes | Z Codes | Description |
|---|---|---|---|
| Behavioral Health | 96156 | | Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making) |
| OB/Gyn | 59400, 59425, 59426, 59430, 59510, 59610, 59618 | Z1000, Z1008, Z1020, Z1032, Z1034, Z1036, Z1038 | Under vaginal delivery, antepartum and postpartum care procedures, under cesarean delivery procedures, under delivery procedures after previous cesarean delivery, under delivery procedures after previous cesarean delivery |
| PCP | 99202-99205, 99461 | Z1016 | Office or other outpatient visit for the evaluation and management of new patient |
| PCP | 99211-99215 | Z00.01, Z00.110, Z00.111, Z00.8, Z02.1, Z02.3, Z02.5 | Office or other outpatient visit for the evaluation and management of an established patient with PCP but new to the Alliance |
| PCP | 99381-99387 | | Comprehensive preventive visit and management of a new patient |
| PCP | 99391-99397 | | Comprehensive preventive visit and management of an established patient with PCP but new to the Alliance |

## Providing Capitated Services to Alliance Group Care Members (PS)

### *SUBMISSION OF CAPITATED SERVICE ENCOUNTERS*

PCPs are capitated for their Alliance Group Care members. Capitated services are the PCP's contractual responsibility. These services are covered by the monthly capitation payment. Capitated services do not require prior authorization.

PCPs must submit capitated services as claims/encounters to the Alliance with the usual and customary billed charges listed. Reported capitated services will appear along with non-capitated services (fee-for-service (FFS) claims) in a Remittance Advice to the PCP, although no payment will be associated with such services.

### *CAPITATED SERVICES TO A NON-ASSIGNED MEMBER*

FFS billing of capitated services is limited to certain situations.

Providers who perform a capitated service for an Alliance member who is not assigned to that provider will only be paid for that service on an FFS basis during the following circumstances:

- Annual gynecological examination
- Diagnosis and treatment of a sexually transmitted disease
- Family planning services
- HIV testing and counseling
- Minor consent services
- Prenatal care (a global fee is paid for this type of care, except for specific procedures)
- The member is not assigned to any PCP
- Vaccination serum, except those covered by the Vaccines for Children (VFC) program

## Non-Capitated Services (PS)

PCPs may provide services within their scope of practice that are not included in the capitation contract for their assigned members. These services are paid on an FFS basis.

Among the non-capitated services that PCPs can provide to their members on an FFS basis are preventive health care visits and inpatient care services.

## Utilization Management (Health Care Services)

***ALL PRIOR AUTHORIZATION MAY BE SUBMITTED VIA THE ALLIANCE PROVIDER PORTAL WITH SUPPORTING CLINICAL DOCUMENTATION.***

# Coordination of Care (Health Care Services)

## PCP Role in Supervision of Mid-Level Clinicians (PS)

### *REQUIREMENTS FOR MID-LEVEL CLINICIANS*

PCPs who employ or contract with mid-level clinicians in their practices are responsible for making sure that the mid-level clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards in order to be credentialed by the Alliance. This helps ensure quality care for members.

### *SCOPE OF PRACTICE*

A supervising physician must define the scope of practice for each mid-level clinician working in the practice. The scope of practice may vary depending on the skills of the individual clinician, but in all cases must comply with applicable state laws.

### *CREDENTIALING*

Any mid-level clinician who provides care to Alliance members must be credentialed by the Alliance. The effective date of a credentialed provider is the first day of the month following the month they were credentialed.

### *DEFINITIONS OF MID-LEVEL CLINICIANS*

Mid-level clinicians are non-physician medical practitioners, including:

- Certified nurse-midwives
- Nurse practitioners
- Physician assistants

**Continuing Education:** All mid-level clinicians must maintain skills in their field of practice through continuing medical education programs, following the guidelines of their respective certifications. The supervising physician should monitor this process.

**Supervision:** All mid-level clinicians must practice under the supervision of a licensed physician and follow medical policies and protocols established by the physician.

### *CHARTS*

Whenever care is provided by the mid-level clinician, the medical record must be reviewed and co-signed by the supervising physician in accordance with the requirements set forth by the clinician's licensing board. The Alliance will audit for compliance with this standard.

### *PCP/MID-LEVEL CLINICIAN RATIOS AND MEMBER CAPACITY*

The number of non-physician medical practitioners who may be supervised by a single

PCP is limited to the following:

- Four (4) nurse practitioners;
- Four (4) nurse-midwives;
- Four (4) physician assistants; or
- Four (4) of the above individuals in any combination

The ratio is based on each physician at any one-time/shift regardless of full-time equivalent status. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits.

The ratio is based on each physician, not the number of offices. A PCP, an organized outpatient clinic, or a hospital outpatient department cannot utilize more non-physician medical practitioners than can be supervised within these stated limits.

### *AFTER-HOURS SERVICE*

Mid-level clinicians may participate in the after-hours call network; however, the supervising physician must also be available for consultation when the mid-level is on-call.

The provider may also refer members to the toll-free Advice Nurse Line, accessible 24 hours a day, 7 days a week:

Medi-Cal Members: **1.888.433.1876**
Group Care Members: **1.855.383.7873**

### *DISCLOSURE*

Members must be informed when a practitioner is a mid-level clinician and must have the opportunity to request a physician if they wish.

### *QUALITY AND UTILIZATION MANAGEMENT*

Contracted organizations are responsible for adherence to contractual obligations and Alliance quality standards for utilization management and quality improvement. The Alliance maintains responsibility for the overall adherence to quality and utilization standards for Alliance members.

Provider responsibilities include the following:

- Completion of corrective action plans as required to improve performance.
- Prompt response to plan requests for medical records or additional information.
- Participation in provider and member satisfaction and timely access surveys.
- Cooperation with Alliance annual audits such as CMS, DHCS, DMHC, NCQA, and ad hoc state and other regulatory audits.
- Development, enactment, and monitoring of a utilization management and/or quality improvement plan that meets contractual requirements and Alliance standards.
- Provide a representative to the Alliance Quality Improvement Health Equity Committee (QIHEC)).
- Provision of encounter information and access to medical records for Alliance members.
- Submission of quarterly reports, annual evaluations, and work plans.
- Submission of utilization management reports based on the delegation agreement.

### *FACILITY SITE REVIEWS (FSR) — MONITORING OF FSR*

Facility Site Reviews (FSR) are the application of prescribed standards by the California Department of Health Care Services (DHCS)/Medi-Cal Managed Care Division (MMCD) for all primary care provider (PCP) sites.

All network PCP sites receive the following:

- An Initial FSR as part of the credentialing process.
    - New PCP sites must pass their Initial FSR and, as applicable, correct all deficiencies in order to close the Corrective Action Plan (CAP) before being added to the network and receiving Alliance member assignments.
- A Medical Record Review (MRR) survey is performed at the time of the FSR if Medi-Cal patient records are available; otherwise, the Alliance must complete the initial MRR of the new PCP site within **90 calendar days** of the date that the Alliance first assigns members.
- A Periodic Full Scope FSR and MRR conducted every **three (3) years** thereafter.
- An Interim Monitoring Review is conducted between each Periodic Full Scope FSR and MRR via an attestation form or on-site review.
- A focused review (targeted review of one (1) or more specific areas of FSR or MRR) may be conducted to investigate problems identified through monitoring activities or to follow up on corrective actions.

- The FSR and MRR are conducted by DHCS-certified nurse reviewers and scored with standardized DHCS guidelines and audit tools.

  The purpose of the reviews is to ensure that:

  - Appropriate primary health care services are provided;
  - Processes that support continuity and coordination of care are consistent;
  - Patient safety standards and practices are maintained; and
  - Clinics operate in compliance with applicable local, state, and federal laws and regulations.

Regulatory agencies may conduct periodic oversight audits of the Alliance's facility site review process. It is the expectation of the Alliance that selected providers will participate in this process.

Each delegate's contract addresses the responsibility for facility site reviews. If the delegated entity is responsible for the review of their provider sites, summary reports must be provided to the plan that includes the number of sites reviewed, deficiencies, and any corrective action plans.

### *POTENTIAL QUALITY ISSUE (PQI)*

A potential quality issue (PQI) is an individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether an actual quality issue exists.

The PQI review, evaluation, and monitoring process applies to all providers rendering services to Alliance members/enrollees on the plan's behalf, within all care settings. The Alliance Quality Improvement (QI) Department has the responsibility for ensuring and maintaining a timely PQI review process from the receipt of all PQI through investigation, appropriate intervention, and resolution. Providers are expected to participate in the PQI process, including submitting medical records or to provide a response to corrective plans to complete the investigation. The Alliance considers this system process a critical component of the QI Program.

# Section 6: Utilization Management

## Overview (Health Care Services)

The Alliance Utilization Management (UM) Department helps ensure the delivery of high-quality, safe, equitable, necessary cost-effective health care for our members to improve health outcomes.

The Alliance UM Department serves to accomplish the following goals:

- Ensure that members receive the appropriate quantity and quality of health care service(s).
- Ensure that service(s) is delivered at the appropriate time.
- Ensure that the care setting in which the service(s) is delivered is consistent with the medical needs of the member.

The Alliance UM Department decisions are based only on the existence of coverage and appropriateness of care and service. The Alliance does not reward or incentivize practitioners or other individuals for issuing denials of coverage, service, or care. There are no financial incentives for the Alliance UM Department to make decisions that would result in underutilization.

### *SCOPE OF UM REVIEWS*

The Alliance UM Department includes appropriately licensed health care professionals to make decisions on provider requests for authorization of services. Authorization decisions are based on eligibility, evidence of coverage, and medical necessity. The Alliance only allows a licensed physician to deny or modify requests for authorization of health care services for reasons of medical necessity. The Alliance uses a variety of sources to assist in making determinations for care.

The Alliance applies the following policies and/or guidelines:

- Alameda Alliance Policy and Procedures for Utilization Management review
- Evidenced-based clinical guidelines
- External specialist review
- MCG® clinical guidelines
- Medi-Cal Policy Guidelines and All Plan Letters
- Member's Evidence of Coverage (benefit coverage)
- The Non-Profit guidelines for Group Care members including the American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Early Childhood Service Intensity Instrument (ESCII) and World Professional Association for Transgender Health (WPATH).

Criteria are applied in conjunction with considering individual needs such as age, co-morbidities, complications, progress of treatment, psychosocial situations and home environment.

### *COMMUNICATION AND AVAILABILITY OF UM STAFF TO MEMBERS AND PRACTITIONERS*

**Peer-to-Peer Discussions**
During the course of a utilization review, Alliance Medical Directors are available for peer-to-peer discussions with physicians to support evidence-based care for our members. Providers may contact Alliance Medical Directors for a peer-to-peer using the Medical Directors' phone number listed on the Notice of Action.

**PLEASE NOTE:** An adverse medical necessity determination cannot be overturned as a result of a peer-to-peer discussion. Providers can file an appeal on behalf of a member, after obtaining member consent, if they do not agree with an adverse medical necessity determination.

## Outpatient (Ambulatory) Services (Health Care Services)

The Alliance provides covered medical benefits for outpatient (ambulatory) services.

These services include, but are not limited to:

- Chiropractic
- Podiatry
- Rehabilitative and habilitative (therapy) services and devices:
    - Acupuncture
    - Audiology
    - Occupational therapy
    - Speech therapy

For a list of services and authorization requirements, please refer to the Alliance Referral and Prior Authorization (PA) Grid for Medical Benefits for Directly Contracted Providers at **www.alamedaalliance.org**. Sensitive services, such as abortion, family planning, sterilization, sexually transmitted diseases, and HIV testing and counseling, do not require prior authorization.

## Biomarkers for Cancer (Health Care Services)

Biomarker testing for members with advanced or metastatic stage 3 or 4 cancer does not require prior authorization. This is intended to remove barriers for members with late-stage cancer allowing them to access cancer biomarker testing to help inform their treatment and expedite care.

**What does this mean for our providers?**

No prior authorization will be required for:

- Advanced or metastatic stage 3 or 4 cancer.
- Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4 cancer.
- Biomarker testing associated with the U.S. Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
- Cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6.

## Standing Referrals (Health Care Services)

The Alliance is required to provide standing referrals to specialists or Specialty Care Centers (SCC) for enrollees who require continuing specialized medical care over a prolonged period of time as part of ongoing ambulatory care or due to a life-threatening, degenerative, or disabling condition. A standing referral allows a member to see a specialist without needing a new referral for each visit when the condition may need an extended period of treatment. Standing referrals may be granted up to a maximum of **12 months**. The PCP or specialist will decide when a member meets the guidelines for a standing referral.

Services shall be authorized as a medically necessary proposed treatment identified as part of the enrollee's care or treatment plan utilizing established criteria and consistent with benefit coverage.

Requests can be made by a member, PCP, specialist, or SCC. A member may request a standing referral through their PCP or specialist. A standing referral made by the PCP is for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis in consultation with the specialist prior to submission of the request. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the PCP with regular reports on the health care provided to the member. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the Alliance, a contracted provider, or a provider group. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the member in the same manner as the member's PCP, subject to the terms of the treatment plan.

Potential conditions for which you may want to consider a request for a standing referral when accessing out-of-network services include, but are not limited to:

- Asthma requiring specialty management
- Cancer
- Chronic obstructive pulmonary disease

- Chronic wound care
- Cystic fibrosis
- Diabetes requiring endocrinologist management
- Gastrointestinal conditions such as severe peptic ulcer, chronic pancreatitis
- Hepatitis C
- HIV/AIDS
- Lupus
- Neurological conditions such as multiple sclerosis, uncontrolled seizures
- Rehab for major trauma, extensive surgery
- Renal failure
- Significant cardiovascular disease

Potential conditions to consider for a standing referral when accessing in-network services include, but are not limited to:

- Burn care
- Chronic wound care
- Professional services that require prior authorization
- Tertiary services

Please include the following information with your request:

- Anticipated length of treatment
- Diagnosis
- Frequency of visits
- Plan of care
- Specify that you are requesting a Standing Referral

How to submit for a standing referral:

- Complete the Alliance Prior Authorization (PA) Request Form
- Submit the request by fax as indicated on the form or through the Alliance Provider Portal.

The turnaround time for standing referrals is **three (3) business days** from the date of receipt.

## Authorizations Requirements (Health Care Services)

The Alliance requires contracted providers to obtain authorization before rendering of services the following services:

- All out-of-network services
- Certain radiology, nuclear medicine, and outpatient services and procedures
- Elective inpatient admissions
- Emergency inpatient admissions

- Skilled nursing/rehabilitation admissions

A complete list of service types and procedures requiring authorizations is available at **www.alamedaalliance.org**.

Claims may not be reimbursed if a rendering provider does not receive an authorization approval from the Alliance or one of our delegated partners before rendering services.

The Alliance will only accept a PA Request Form from the treating provider who determined the medical necessity for the requested services or procedure.

The treating provider is defined as the facility, PCP, behavioral health, or specialty clinician who is currently providing care to the member. This includes attending clinicians at a hospital or skilled nursing facility responsible for the member's discharge planning.

For services that do not require prior authorization, but are associated with a service on prior authorization, there must be an approved authorization on file for the primary service requiring authorization for the associated code(s) to be paid. Associated service codes will not be paid separately if the primary service is denied.

### *NOTIFICATION REQUIREMENTS FOR ACUTE INPATIENT CARE*

Contracted facilities must notify the Alliance within **24 hours** of an acute admission. Non-contracted facilities must notify the Alliance as soon as the member's medical condition has been stabilized per California Health and Safety Code Section 1262.8.

All facilities, contracted and non-contracted, must notify the Alliance within **24 hours** of a change in the level of care or discharge from the facility (including skilled nursing facilities).

Upon request, facilities must submit clinical information to the Alliance UM Department by the end of the next business day from the time of the request.

Admission notifications should be faxed to the Alliance UM Department at **1.855.313.6306**. Clinical information can be faxed to **1.855.891.7409**.

Notifications and clinical notes received outside of the above time frames may result in a denial of the authorization for service and payment s.

### *PROCESS FOR REQUESTING AUTHORIZATION*

Unless otherwise indicated, the information provided in this section applies to both contracted and non-contracted providers providing care for an Alliance member assigned to a PCP. Providers are expected to adhere to the process below.

### *ELECTRONIC SUBMISSION OF PRIOR AUTHORIZATION REQUESTS*

Providers can complete and submit an electronic submission of outpatient or IP elective

authorization requests by using the Alliance Provider Portal.

Login to the Alliance Provider Portal using Google Chrome and follow these steps:

Step 1. Click 'Submit Authorizations' under the Authorization quick link.
Step 2. Click 'Select a form' and choose from the appropriate drop-down:
- Inpatient Authorization (elective procedures only)
- Outpatient Authorization

Step 3. Enter all required fields as directed in this section.
Step 4. Attach medical records to avoid further delay of the review or possible denial of services.
Step 5. Click 'Submit request' once you are ready to submit.

### *FAX SUBMISSION OF PRIOR AUTHORIZATION REQUESTS*

**Providers can obtain a PA Request Form from the Alliance through any of the following:**

- Alliance Provider Services Department: **1.510.747.4510**
- Alliance UM Department: **1.510.747.4540**
- Alliance Provider Portal: Visit **www.alamedaalliance.org** and click on the 'Provider Portal' link located at the top right banner. After you sign in, you will be able to view and download the form.
- Alliance Website: **www.alamedaalliance.org/providers/provider-forms**

### *IMPORTANT REMINDERS WHEN SUBMITTING AUTHORIZATION REQUESTS*

1. Confirm member eligibility with the Alliance:
   - Alliance Automated Eligibility Verification System: **1.510.747.4505**
   - Online: **www.alamedaalliance.org**
     - Select 'Provider Portal – check member eligibility.'
     - Select an Alliance participating provider.
   - Online: **www.alamedaalliance.org**
     - Select 'Provider Portal – check the provider directory.'

2. Complete all required items on the PA Request Form, or as indicated on the Alliance Provider Portal, for the requested service.

3. Follow separate processes for durable medical equipment (DME) and prescription drug prior authorization (PA) requests. Please see below for additional instructions on submitting authorizations for these other services.

4. To ensure timely processing, please indicate whether the request is "Urgent," "Routine," or "Retro" on the PA Request Form.
   - When requesting an urgent review timeframe (within **72 hours**), the urgency

for the service being requested must be necessary due to an imminent and serious threat to the member's health, including, but not limited to, the potential loss of life, limb, or other major bodily function.

- All PA requests marked urgent will be reviewed by an Alliance Medical Director (physician) to determine if the supporting documentation for the request meets the definition of an urgent/expedited request as outlined above. If it does not, the request will be modified to a routine timeframe (**five (5) business days**) from the date of receipt. Providers will be notified of this change.

- You may submit the PA Request Form to the Alliance UM Department by mail, or fax:

  Mail: Alameda Alliance for Health
  Health Care Services Department
  1240 South Loop Road
  Alameda, CA 94502

  Fax: **1.855.891.7174**

Providers may call the UM Department by phone at 1.510.747.4540 for any questions or assistance with the authorization forms or process.

**PLEASE NOTE:** Always retain a copy of the completed PA Request Form in the patient's medical record.

### *CONCURRENT AUTHORIZATION SUBMISSION*

Confirm member eligibility with the Alliance:

- Phone Number: **1.510.747.4505**
- Online: **www.alamedaalliance.org**
  - Select 'Provider Portal' and log in to check member eligibility.

Fax initial admission hospital face sheet, census report, and all relevant clinical information to **1.855.313.6306**.

Fax changes to the level of care and daily updated clinical information to **1.855.891.7409**.

### *AUTHORIZATION NOTIFICATION OF DETERMINATION DECISIONS*

An authorization number, along with any quantity and date limits, will be given for all authorizations, regardless of the determination status.

Notification to members and providers/facilities are provided within **24 hours** of the review determination.

Providers are notified electronically. Members receive notifications via a mailed..

Members with questions about their notification, or who need language assistance may call:

Alliance 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**

To request a copy of the criteria used in the review, providers may contact:

Alliance Authorization Department
Phone Number: **1.510.747.4540**

Provider confidentiality will be maintained regarding releasing criteria related to a specific case.

### *AUTHORIZATION REVIEW TIMELINESS STANDARDS*

The Alliance processes authorization requests in a timely manner and in accordance with regulatory requirements.

The Alliance will make a determination within the following time frames:

| REQUEST TYPE | MEDI-CAL | GROUP CARE |
|---|---|---|
| Urgent | **72 hours** | **72 hours** |
| Routine | **5 business days** | **5 business days** |
| Concurrent | **72 hours** | **72 hours** |
| Retrospective/Post Service | **30 calendar days** | **30 calendar days** |
| Standing Referral | **3 business days** | **3 business days** |

When there is insufficient information to support a determination decision, the request will be deferred for up to **14 calendar days** from the initial date the authorization request was received, while additional information is gathered from the requesting provider. The Alliance will notify the provider and the enrollee, in writing, that a decision cannot be made within the required time frame, and specify the information needed. The Alliance will specify the anticipated date on which a decision may be rendered in accordance with regulatory timeframes. If the provider has not submitted the requested medical information by the stated deadline, the request may be denied.

A request for an elective (non-urgent) surgery or treatment submitted urgently due to the imminent date of service is not considered to be urgent. Urgent is defined by DHCS as an immanent and serious threat to the member's health, including, but not limited to the potential loss of life, limb, or other major bodily function. Therefore, requests should only be made when care is needed within **24-72 hours** or the member is at risk for serious

harm should care be delayed. Inappropriate use of the "urgent" category will be monitored.

**Retrospective/Post-Service Process**
Retrospective/post-service review is the process in which utilization review is used to determine medical necessity or coverage under the health plan benefit **after** health care services or supplies have been provided to a member and a prior authorization was not obtained.

The Alliance does not require prior authorization for emergency or urgent services.

> **REMINDER:** To obtain prior authorization for non-emergency or non-urgent services, the Alliance offers access to submit requests through the Alliance UM Department, 24 hours a day, 7 days a week.
>
> Providers may contact:
>
> > Alliance Utilization Management (UM) Department
> > Phone Number: **1.510.747.4540**
> > To submit a request via E-Fax line: **1.855.891.7174**
>
> The Alliance maintains and publishes a list of services that require prior authorization. The list is accessible at **www.alamedaalliance.org/providers/authorizations**.

Retrospective requests submitted within **90 calendar days** of the date of service will be reviewed by the Alliance UM Department for medical necessity. Determinations on retrospective requests are made within 30 calendar days of the receipt of the request, per regulatory guidelines.

There are two (2) exceptions under which a retrospective request beyond **90 days** from the date of service may be considered (documentation is required):

1. Member eligibility – Incorrect eligibility was given or unable to validate eligibility with the Alliance at the time of service.
2. Inpatient services – The facility is unable to confirm enrollment with the Alliance.

**PLEASE NOTE:** Retrospective/post-service requests are not considered urgent, and will not be processed as such. Requests for services that do not meet the criteria above are subject to denial, as no authorization has been obtained.

## *TRACKING AND MONITORING OF SERVICES AUTHORIZED*

The Alliance tracks and monitors services authorized to specialists, including open or unused approved authorizations. This process is in place to ensure that services authorized are utilized within the authorized time duration. A monitoring report will be reviewed to evaluate whether there are access constraints for certain providers and specialties, as well as to identify any members who continuously do not utilize approved

authorizations for possible referral to case management to help coordinate their care.

## Continuity of Care (CoC) (Health Care Services)

Beneficiaries who are mandated to transition from Medi-Cal fee-for-service (FFS) and enroll as members in a managed care plan (MCP), transition from MCPs with contracts expiring, or have providers who terminate contracts with the MCP, have the right to request continuity of care (CoC) with a Provider for a covered benefit if a verifiable pre-existing relationship exists with that Provider.

CoC protections extend to the following providers:

- Primary Care Providers
- Specialists
- Select Ancillary Providers:
    - Physical Therapy
    - Occupational Therapy
    - Respiratory Therapy
    - Behavioral Health Treatment (BHT)
    - Speech Therapy

CoC protections do not extend to the following providers:

- Radiology
- Laboratory
- Dialysis Centers
- Non-Emergency Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Other Ancillary Services
- Non-enrolled Medi-Cal Providers

Members, authorized representatives (AOR), or providers may request up to **12 months** of CoC with a provider. CoC requirements include:

1. The MCP determines the Member has a pre-existing relationship with the provider (a pre-existing relationship means the member has seen the OON provider for a non-emergency visit, at least once during the 12 months prior to the date of their initial enrollment in the MCP)
2. The provider is willing to continue to see the member.
3. The provider is willing to accept the MCP's contract rates or Medi-Cal FFS rates.
4. The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues; and
5. The provider is a California State Plan approved provider (a list of suspended or ineligible Providers is available here: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/ references/sandi)

**12-month CoC Period Restart:**

1. After a mandatory transition into the MCP, if a member changes MCPs by choice following the initial enrollment in an MCP during the 12-month CoC period, the 12-month CoC period for a pre-existing provider **may start over one time.**

   **Example:** If a Member enrolls in an MCP on January 1, 2023, but then later changes MCPs by choice on April 1, 2023, then the 12-month Continuity of Care may start over one time and the Member may see the Provider until April of the following year.

2. After a mandatory transition into the MCP, if a member loses and then later regains MCP eligibility during the 12-month CoC period, then the 12-month CoC period for a pre-existing provider **may start over one time**.

3. If the Member changes MCPs or loses and then later regains MCP eligibility a second time (or more), the CoC period **does not start over** and the member does not have the right to a new 12 months of CoC.

4. If the member returns to Medi-Cal FFS (if applicable) and later re-enrolls in an MCP, the CoC period **does not start over**.

Additionally, if a member has one of the below conditions listed in Health and Safety Code (HSC) section 1373.96, CoC is provided for the completion of a course of treatment for that specific condition by a terminated or out-of-network provider, at the member's request.

| **Health condition** | **Time period** |
|---|---|
| Acute conditions (a medical issue that needs fast attention) | For as long as your acute condition lasts |
| Serious chronic physical and behavioral conditions (a serious health care issue you have had for a long time) | For an amount of time required to finish your course of treatment and to safely move you to a new doctor in the Alliance network |
| Pregnancy and postpartum (after birth) care | During your pregnancy and up to 12 months after the end of pregnancy |
| Maternal mental health services | For up to 12 months from the diagnosis or from the end of your pregnancy, whichever is later |
| Care of a newborn child between birth and 36 months old | For up to 12 months from the start date of the coverage or the date the provider's contract ends with the Alliance |
| Terminal illness (a life-threatening medical issue) | For as long as your illness lasts. You may still get services for more than 12 months from the date you enrolled with the Alliance or the time the provider |

| | |
|---|---|
| | stops working with the Alliance |
| Performance of a surgery or other medical procedure from an out-of-network provider as long as it is covered, medically necessary, and authorized by the Alliance as part of a documented course of treatment and recommended and documented by the provider | The surgery or other medical procedure must take place within 180 days of the provider's contract termination date or 180 days from the effective date of your enrollment with the Alliance |

**NOTE:** If an MCP is not able to come to an agreement with the terminated Provider or out-of-network Provider, or if the Member, authorized representative, or Provider does not submit a request for the completion of Covered Services by said Provider, the MCP is not required to continue the Provider's services.

**Continuity of Care for Covered Services and Prior Treatment Authorizations**

For members who mandatorily transition from Medi-Cal FFS to the Alliance with active prior treatment authorizations for services, those services must be honored for **90 days** from the date of enrollment without a request by the member, authorized representative or provider. Services authorized under the active treatment authorization should be arranged with an **in-network provider**, or **if there is no in-network provider to provide the service, with an OON provider**. After **90 days**, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment, whichever is shorter. A new assessment is considered complete if the member has been seen in-person and/or via synchronous Telehealth by a Network Provider and this provider has reviewed the member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

**A. Durable Medical Equipment (DME) rentals and medical supplies**:

Members who mandatorily transition from Medi-Cal FFS to the Alliance are allowed to keep their existing DME rentals and medical supplies from their **existing** providers under the previous Prior Authorization for a minimum of **90 days** following MCP enrollment and until the MCP can reassess, the new equipment or supplies are in possession of the member, and ready for use. Continuity of DME and medical supplies must be honored without request by the member, authorized representative or provider. After 90 days, the MCP may reassess the member's authorization at any time and require the member to switch to an in-network DME provider.

**NOTE:** If DME or medical supplies have been arranged for a transitioning member, but the equipment or supplies have not been delivered, the MCP must allow the delivery and for the member to keep the equipment or supplies for a minimum of 90 days following MCP enrollment and until reassessment.

**B. Non-Emergency Medical Transportation and Non-Medical Transportation:**

Members who mandatorily transition from Medi-Cal FFS to the Alliance must be allowed to keep the **modality** of transportation under the previous prior authorization with an in-network provider until the MCP is able to reassess the member's continued transportation needs.

Additional information on CoC for Medi-Cal members is found here: https://www.dhcs.ca.gov/services/Pages/Continuity-of-Care.aspx#coc.

CoC for Group Care is available in the following scenarios:

1. Acute condition – Completion of covered services shall be provided for the duration of the acute condition.
2. Pregnancy (including care after the birth) – Completion of covered services shall be provided for the duration of the pregnancy when (1) the pregnancy is high-risk, or (2) the member is in their second or third trimester.
3. Serious chronic condition – Completion of covered services shall be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the member and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed **12 months** from the time of enrollment with the Alliance.
4. Surgeries and/or procedures – Performance of surgeries and/or other procedures that the member's previous plan authorized as part of a documented course of treatment, and that had been recommended and documented by the non-participating provider to occur within **180 days** of the time the member enrolled with the Alliance.
5. Terminal illness – Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed **12 months** from the time of enrollment with the Alliance.

Specific provider requirements for coverage are:

1. The provider has had a pre-existing relationship within the last **12 months** for non-urgent services.
2. The provider is willing to continue to see the member.
3. The provider is willing to complete a letter of agreement for payment.

## Doula Services (Health Ed)

Doulas services are covered for prenatal, perinatal, and post-partum members as preventive services and are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants. Doulas are birth workers who provide person-centered, culturally competent health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion. Doulas are not licensed and do not require supervision. Doulas offer various types of support,

including health navigation, lactation support, the development of a birth plan, and linkages to community-based resources.

Services can be provided virtually or in-person with various locations including, but not limited to:

4. Homes
5. Office visits
6. Hospitals
7. Alternative birth centers

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure. Doulas are required to enroll as Medi-Cal providers.

The California Department of Health Care Services (DHCS) issued a statewide standing recommendation for doula services. The recommendation covers all Medi-Cal members who are pregnant or have been pregnant within the past year and would benefit from doula services. Services include:

One initial visit
Up to eight additional prenatal and postpartum visits
Support during labor and delivery (including stillbirth, abortion, or miscarriage)
Up to two three-hour postpartum visits after the end of a pregnancy.

Providers do not need to complete a recommendation form for the initial nine doula visits.

Members may receive up to nine additional postpartum visits with a written recommendation from a physician or other licensed practitioner of the healing arts (LPHA) acting within their scope of practice. The recommending practitioner does not need to be enrolled in Medi-Cal or be a network provider with the Plan.

An LPHA may include any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT), or licensed-eligible practitioner working under the supervision of a licensed clinician.

The recommendation for additional doula services can be found here.

The Alliance will work with network hospital/birthing centers as needed to ensure that doulas will not have any barriers to accessing these providers when accompanying members for delivery, regardless of the outcome.

Alliance members can access doula services by:

- Calling the Alliance Member Services Department at 1.510.747.4567, or
- Searching the Alliance Provider Directory https://alamedaalliance.org/help/find-a-doctor/ and contact a doula directly.

## Enteral Nutrition Formulas for Medi-Cal Members (Health Care Services/Pharmacy)

Enteral nutrition formula for Medi-Cal members is covered by Medi-Cal Rx as a pharmacy benefit. No changes will occur to how enteral supplies such as pumps, tubing, or general enteral nutrition products are submitted. The Alliance or delegate group will still authorize these supplies.

A list of covered enteral nutrition products can be found on the Medi-Cal Rx Covered Product List **https://medi-calrx.dhcs.ca.gov/provider/forms**. Providers may call Medi-Cal Rx toll-free at **1.800.977.2273**.

Parenteral services will continue under the medical benefit and be reviewed by the Alliance or assigned delegate group.

Enteral nutrition for Group Care will remain with the Alliance or assigned delegate group and follow the general prior authorization processes and form for submission.

## Continuous Glucose Monitor (CGM) Devices for Medi-Cal Members (Health Care Services/Pharmacy)

Continuous glucose monitors (CGM) for Medi-Cal members are covered by Medi-Cal Rx as a pharmacy benefit.

A list of covered CGM products and coverage criteria can be found on the Medi-Cal Rx Covered Product List at **https://medi-calrx.dhcs.ca.gov/provider/forms**. Providers may call Medi-Cal Rx toll-free at **1.800.977.2273**.

CGM products for Group Care members are covered by the Alliance or assigned delegate group and follow the general prior authorization processes and form for submission.

## Palliative Care (Health Care Services)

The Alliance authorizes palliative care services to its Medi-Cal members when these

services are medically necessary. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the Alliance's contracts and does not affect a member's ability to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care.

### *ELIGIBILITY CRITERIA*

Member must meet at least one (1) of the following:

1. Member likely to or has started to use hospital or emergency department to manage their advanced disease (excluding elective procedures).
2. Member has advanced illness, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. Clinician feels that member's death within a year would not be unexpected based on clinical status.
4. Member has either received appropriate patient-desired medical therapy or is a member for whom patient-desired medical therapy is no longer effective.
5. Member is not in reversible acute decompensation.
6. Member, and if applicable, family/patient designated support person agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    b. Participate in advance care planning discussions.

### *DISEASE-SPECIFIC ELIGIBILITY CRITERIA*

The member has one (1) of the following conditions:

1. Congestive heart failure (must meet both of the following):
    a. New York Heart Association class 3 or higher or at least one (1) hospitalization for heart failure in **six (6) months** with no further invasive interventions planned; and
    b. Ejection Fraction <30% for systolic failure or significant comorbidities.
2. Chronic obstructive pulmonary disease (COPD) (must meet either of the following):
    a. Forced Expiratory Volume (FEV) 1 less than 35% and 24-hour oxygen requirement of less than 3L; or
    b. 24-hour oxygen requirement of greater than or equal to 3L per minute.
3. Advanced cancer (must meet both of the following):
    a. Stage 3 or 4 solid organ cancer, lymphoma, or leukemia; and
    b. A Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two (2) lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver disease (must meet either of the following):
    a. Evidence of irreversible liver damage, serum albumin < 3 and INR > 1.3 and ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

   b. Model of End Stage Liver Disease (MELD) score of greater than 19.
5. Advanced dementia and Alzheimer's dementia (must meet four (4) out of the five (5) criteria indicated below for coverage):
   a. Decreased oral intake and/or significant weight loss in the last six (6) months
   b. Functional impairment (ADL dependencies)
   c. Malnutrition
   d. Minimal communication
   e. Profound memory deficits

- Other serious and advanced illnesses, as diagnosed by a doctor.

## Palliative Care Services (Health Care Services)

Palliative care services may be authorized while the member is also receiving curative care and until the condition improves, stabilizes, or results in death.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care (LTC) facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals.

Palliative care services include, at a minimum, the following seven (7) services when medically necessary and reasonable for the management of a qualified serious illness:

1. Advance care planning: Advance care planning for beneficiaries enrolled in Medi-Cal palliative care includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST12) forms.
2. Palliative care assessment and consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations.

   Topics may include, but are not limited to:

   f. Advance directives, including POLST forms
   g. Emotional and social challenges
   h. Legally recognized decision maker
   i. Pain and medicine side effects
   j. Patient goals
   k. Spiritual concerns
   l. Treatment plans, including palliative care and curative care
3. Plan of care: A plan of care is developed with the engagement of the member and/or their representative(s) in its design. If a member already has a plan of

care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.

4. Palliative care team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of members and their families and can assist in identifying sources of pain and discomfort of the member. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health needs. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team includes, but is not limited to the following team members, a Doctor of Medicine or osteopathy (PCP if MD or DO), a registered nurse, a licensed vocational nurse or nurse practitioner (PCP if NP), and/or a social worker.
5. Care coordination: A member of the palliative care team provides coordination of care, ensures continuous assessment of the member's needs and implements the plan of care.
6. Pain and symptom management: Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy, and other medically necessary services may be needed to address beneficiary pain and other symptoms. The member's plan of care includes all services authorized for pain and symptom management.
7. Mental health and medical social services: Counseling and social services are available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. The provision of medical social services does not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs) and does not change the Alliance's responsibility for referring to and coordinating with county MHPs.

## Delegation of UM to Medical Groups (Health Care Services)

Members may be assigned to a PCP who is not directly contracted with the Alliance and who belongs to one (1) of the following medical groups who performs utilization management:

1. Children First Medical Group (CFMG) – Medi-Cal only
2. Community Health Center Network (CHCN) – Medi-Cal and Group Care

Our medical groups adhere to the same regulatory standards for UM as outlined above. With some exceptions, a provider serving an Alliance member as part of a medical group must verify authorization rules and obtain any required authorizations from the medical group. Providers can verify a member's group assignment by using one (1) of the Alliance's eligibility verification methods.

Behavioral Health Services are not delegated. The Alliance directly manages mental health services for Medi-Cal members with mild-moderate mental health conditions. The Alliance directly manages all behavioral health services for Group Care members.

### *DURABLE MEDICAL EQUIPMENT (DME)*

The Alliance contracts with California Home Medical Equipment (CHME) for authorization management and servicing of certain durable medical equipment (DME) services to all members. .

CHME manages the following service categories:

1. Breast pumps
2. Continuous glucose monitoring (CGM) services for Group Care only
3. Diabetic Shoes
4. Home respiratory equipment
5. Hospital beds /decubitus care equipment
6. Incontinence supplies
7. Lymphedema products
8. Medical supplies; wound care, ostomy, and urological supplies
9. Nutritional supplements and feeding supplies
10. Other home medical supply needs
11. Wheelchairs, walkers, canes, and other ambulatory aids

**PA requests for DME should be directed to CHME for processing.** A complete list of service codes managed by CHME is available in the Alliance prior authorization gride under DME at **www.alamedaalliance.org**.

Please ensure that CHME has the following information to promptly review the request:

1. Delivery address (equipment cannot be delivered to a PO Box)
2. Diagnosis for equipment
3. Member's height and weight
4. Order/prescription from the prescribing provider
5. Progress notes related to the equipment
6. Settings for oxygen and PAP devices
7. Test results such as oxygen saturation and/or ABGs

***FOR SERVICES EXCLUDED FROM CHME'S SERVICE CATEGORIES, THE ALLIANCE CONTRACTS WITH A SELECT GROUP OF DME PROVIDERS. PROVIDERS SHOULD SUBMIT A PA REQUEST DIRECTLY TO THE ALLIANCE UM DEPARTMENT OR A MEMBER'S ASSIGNED DELEGATED GROUP FOR THESE***

***EXCLUDED SERVICES.. DIVISION OF UM RESPONSIBILITY WITH ALLIANCE MEDICAL GROUPS AND VENDORS***

This grid is meant to direct providers to submit prior authorizations to the correct entity.

| DELEGATED MEDICAL GROUP | PHONE NUMBER | WEBSITE |
|---|---|---|
| Children First Medical Group (CFMG) | Phone Number: **1.510.428.3154**<br>Fax: **1.510.450.5868** | **www.childrenfirstmedicalgroup.org** |
| Community Health Center Network (CHCN) | Phone Number: **1.510.297.0220**<br>Fax: **1.510.297.0222** | **www.chcnetwork.org** |
| California Home Medical Equipment (CHME) | Phone Number: **1.650.357.8550**<br>Fax: **1.650.931.8928** | **www.chme.org**<br>To send orders by email: **orders@chme.org** |

## Provider-to-Provider Communication (Health Care Services)

In order to ensure coordinated care when referring members for specialty services, the following communication and documentation guidelines must be followed.

### *PCPS*

Provide the specialist with the following information:

1. Condition/reason for referral
2. Document the referral in the member's medical record
3. Member name/Alliance member ID number
4. Member's preferred language
5. PCP's name
6. Provide the member with the referral information
7. Refer to network providers only – check the most recent online provider directory for a complete listing of current Alliance specialists
8. Relevant clinical information

### *SPECIALISTS*

Please complete the following:

1. Document the referral information in the member's medical record
2. Provide regular feedback to the PCP
3. Verify the member's eligibility at the time of service
4. Verify the referral from the member's PCP or obtain authorization from the

Alliance for services requiring prior authorization

## Transplant Services, including Major Organ Transplants (MOT) (Health Care Services)

Effective January 1, 2022, the Alliance covers the Major Organ Transplant (MOT) benefit for adult and pediatric transplant recipients and donors.

Medi-Cal members identified by Alliance providers as potential candidates for MOT/ Bone Marrow Transplants (BMT) procedures should be promptly referred to a Medi-Cal-approved Center of Excellence (COE) for transplant evaluation.

The Alliance will cover all medically necessary services for transplant recipients and both living donors and cadaver organs for the following major organs:

- Bone marrow
- Heart
- Heart-lung
- Kidney
- Liver
- Intestine
- Lung
- Kidney-pancreas
- Pancreas

Medi-Cal members for whom a transplant procedure authorization is denied will continue to receive primary care and treatment services from the Alliance.

All beneficiaries previously disenrolled to fee-for-service (FFS) and who were approved for a transplant prior to Sunday, January 1, 2022, will remain in FFS Medi-Cal until they receive a transplant.

### *TRANSPLANT AUTHORIZATION PROCESS FOR PCP AND SPECIALISTS*

The PCP or attending specialist must send an authorization request to the Alliance Utilization Management (UM) Department for a member seeking an evaluation as a potential candidate for a transplant.

The Alliance must directly refer adult beneficiaries or authorize referrals to a transplant program for an evaluation within **72 hours** of a beneficiary's PCP or specialist identifying the beneficiary as a potential candidate for transplant and receiving all the necessary information to make a referral or authorization.

The Alliance must refer pediatric beneficiaries to the County California Children's Services (CCS) program for CCS eligibility determination within **72 hours** of the

beneficiary's PCP or specialist identifying the beneficiary as a potential candidate for transplant. The County CCS program will be responsible for referring the CCS-eligible beneficiary to the transplant Special Care Centers (SCC).

If the CCS program determines that the beneficiary is not eligible for the CCS program, but the transplant is medically necessary, the Alliance maintains complete responsibility for the medical care of that member.

### *TRANSPLANT CENTERS*

If the transplant program confirms that the beneficiary is a suitable transplant candidate, the Alliance will be required to authorize the request for the transplant. The transplant program is responsible for placing beneficiaries on the National Waitlist maintained by the Organ Procurement and Transplantation Network (OPTN), administered by the Health Resources and Services Administration (HRSA), once it has determined that the beneficiary is a suitable transplant candidate.

### *COORDINATION OF CARE*

The Alliance Health Care Services Department must ensure care management for all covered services and coordination of care for beneficiaries between all providers, organ donation entities, and transplant programs to ensure the transplant is completed as expeditiously as possible. The Alliance, Centers of Excellence (COE), or CCS will be responsible for providing care management and care coordination services to the transplant recipients as well as the living donors.

### *TRANSPLANT APPROVED*

If the member is approved for transplant by CCS or the COE, then the member will not be disenrolled from the plan. The Alliance-contracted PCP and/or specialist will continue to be responsible for transferring the member's medical records directly to the COE or CCS as requested.

### *TRANSPLANT NOT APPROVED*

If the member is not approved for the transplant, the Alliance will continue case management of the member in coordination with the PCP for ongoing care. The member's eligibility will continue with the Alliance until deemed otherwise.

## Minor Consent Services (PS)

Children **18 years of age** or under may get certain confidential services without parental approval.

Minor consent services are services related to:

1. Diagnosis and treatment of sexually transmitted diseases
2. Drug or alcohol use services*
3. Family planning services

4. Medical care after a sexual assault
5. Outpatient mental health care services*
6. Pregnancy

*Children must be **12 years of age** or older to receive drug and alcohol abuse services and outpatient mental health care services without parental approval.

Providers can call the Alliance Member Services Department to find out how to coordinate minor consent services. Members can also receive minor consent services from a non-Alliance provider that accepts Medi-Cal. PCPs do not have to authorize these services.

## Vision Care Services (PS)

The Alliance contracts with MARCH Vision Care to provide routine eye care services to Alliance Medi-Cal members and covers:

7. Routine eye exam once every **24 months**
8. Eyeglasses (frames and lens) once every **24 months**; contact lens when required for medical conditions such as aphakia, aniridia, and keratoconus

Prior authorization is not needed for appointments.

For questions or to request a provider directory, please contact:

MARCH Vision Care
Toll-Free: **1.844.336.2724**
To request online: **www.marchvisioncare.com**

The MARCH Vision Care provider will send a report to the patient's PCP after the visit which will include all diagnoses discovered during the vision exam. The vision provider will make a referral to the member's PCP whenever a medical problem is detected.

Group Care members have access to vision care services through their specific plans. Members should contact their vision plan for more information.

## Hospice Services (Health Care Services)

The Alliance will provide reimbursement for hospice care for members who are certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

A member who elects to receive hospice care must file an election statement with the hospice providing the care.

The election statement must include:

1. Identification of the hospice
2. The member's or representative's acknowledgment that:
    a. A member or representative may:

i. Execute a new election for any remaining entitled election period at any time after revocation;
ii. Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

b. A member's voluntary election may be revoked or modified at any time. The member must file a signed statement with the hospice revoking the member's election for the remainder of the election period.

3. The effective date of the election.
4. The signature of the member or representative.
5. They have a full understanding that the hospice care given as it relates to the member's terminal illness will be palliative rather than curative in nature.

## Long-Term Care (LTC) (Medi-Cal Only) (LTSS)

The Alliance is responsible for long-term care (LTC) services for Alliance Medi-Cal members. LTC may be provided in facilities, including Skilled Nursing facilities providing custodial care, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes, and Subacute Facilities.

If an Alliance member requires LTC placement, facilities need to request authorization prior to admission. If that is not possible due to an urgent need of an admission, the Alliance must be notified within 24 hours of admission. All out-of-network admissions also require a prior authorization (PA) request. To extend an authorization, a reauthorization should be submitted to the Alliance as early as 60 days, but no later than one (1) week prior to the expiration of the existing authorization for the member. For authorization turnaround timeframes, please see the table below.

| REQUEST TYPE | TURN AROUND TIME |
|---|---|
| Urgent | **72 hours** |
| Routine | **5 business days** |
| Retrospective/Post Service | **30 calendar days** |

The facility is responsible for notifying the Alliance of any change in the level of care within 24 hours of the change. The facility must request a new authorization any time the member's level of care changes. The facility must also notify the Alliance of any member admissions to the hospital (need for a bed hold), transfer to other levels of care, discharges, and expirations.

The facility is responsible for communicating any discharge plans or needs for members transitioning back into the community, prior to the discharge.

For more information, facilities may contact:

Alliance LTC Department
Phone Number: **1.510.747.4516**
Fax: **1.510.747.4191**
Email: **LTCHCS@alamedaalliance.org**

### *DOCUMENTATION*

Providers must send the Alliance a complete history of the illness including diagnostic tests, procedures, and treatments from all physicians involved in the member's care. Documentation must include a statement from the provider that verifies that the member will be an LTC resident, and all required documentation based on care level (i.e., Physicians order, HS 231, IPP, PASRR, MDS, etc). To Access the Alliance Prior Authorization (PA) Request Form, please visit the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

### *LTC CLAIMS*

Claims must be submitted utilizing the UB-04 claim form. Medi-Cal has issued the code sets to be used on the UB-04 claim form for each accommodation code and its related revenue and value codes. The only current acceptable accommodation codes that the Alliance accepts for billing are for NF-B & NF-A regular patient room & board (R&B), leave of absence days, and bed holds for custodial care.

For more information on accommodation codes, please visit **https://files.medi-cal.ca.gov/pubsdoco/hipaa/crosswalks/ltc_accommodation_code_to_revenue_code_value_code_and_value_code_amount_crosswalk.pdf**.

### *ADDITIONAL COSTS FOR LTC MEMBERS*

**Medi-Cal Share of Cost**

Some Medi-Cal subscribers must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal subscriber's SOC is similar to a private insurance plan's out-of-pocket deductible. It is expected the provider will collect this SOC prior to billing the Alliance and show the collected amount in the Value Code section of the UB-04 claim form.

## Community-Based Adult Services (CBAS) (Health Care Services)

Community-Based Adult Services (CBAS) is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Alliance members. The Alliance authorizes CBAS based on a referral from the member's PCP and an eligibility assessment completed by a CBAS provider.

### *CBAS MEDICAL NECESSITY CRITERIA*

Except for those residing in an Intermediate Care Facility, Developmentally Developed-

Habilitative ICF/DD-H members must meet all of the following medical necessity criteria to qualify for CBAS:

1. A high potential exists for the deterioration of the member'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 are not provided.
2. The member has one (1) or more chronic or post-acute medical, cognitive, or mental health condition(s) identified by the member's personal health care provider as requiring monitoring, treatment, or intervention, without which the member's condition(s) will likely deteriorate and require emergency department (ED) visits, hospitalizations, or other institutionalization.
3. The member has at least one (1) of the following:
    a. Mild cognitive impairment
    b. Organic, acquired, or traumatic brain injury
    c. Chronic mental illness
4. The member suffers from moderate to severe dementia
5. The member has a developmental disability
6. The member's condition(s) require all core CBAS performed on each day of attendance to be individualized and designed to maintain the ability of the member to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.
7. Core services include:
    a. Meal service/transportation
    b. Personal care services/social services
    c. Professional nursing services (which include observation, assessment, and monitoring of member's health status and medications; communication with member's health care providers regarding changes in health status; supervision of personal care services; and/or skilled nursing care and intervention)
    d. Therapeutic activities
8. The participant's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by at least one (1) of the following:
    a. The member has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the member.
    b. The member lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.
    c. The member resides with one (1) or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the member.

## Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) (Health Care Services)

Community-Based Adult Services (CBAS) Emergency Remote Services (ERS) services

ensure each member's needs continue to be met if the member is unable to return physically to a CBAS center for services. The goal is to support seniors and persons with disabilities (SPD) and their families and caregivers where and when services are needed. This expands access to home and community-based services to support individuals remaining in their homes and communities. CBAS ERS is the temporary provision and reimbursement of CBAS in alternative settings in the community, the participant's home, or via telehealth to allow for immediate response during CBAS participant emergencies.

CBAS ERS is available only to CBAS participants.

A CBAS participant is defined as a member who:

1. Is eligible for CBAS by the Alliance
2. Has completed a person-centered care plan
3. Has an approved authorization on file; and
4. Signed a CBAS participation agreement at the CBAS Center

There are two (2) unique circumstances that may result in the need for ERS services.

The provision of ERS supports and services is temporary and time-limited:

1. **Short-term:** Members may receive ERS for an emergency occurrence for up to **three (3) consecutive months**. CBAS providers and MCPs must coordinate to ensure the duration of ERS is appropriate during the member's current authorized period and, as necessary, for reauthorization into a new period; or
2. **Beyond three (3) consecutive months:** ERS for an emergency occurrence may not exceed **three (3) consecutive months**, either within or crossing over an authorized period, without assessment and review for the possible continued need for remote/telehealth delivery of services and supports as part of the reauthorization of the individual's care plan. CBAS providers and MCPs must coordinate requests for authorization of ERS that exceed **three (3) consecutive months**.

The two (2) types of circumstances for ERS are:

1. Public emergencies, such as state or local disasters, regardless of whether formally declared. These may include but are not limited to earthquakes, floods, fires, power outages, and epidemic/infectious disease outbreaks such as COVID-19, tuberculosis, norovirus, etc.
2. Personal emergencies, such as serious illness or injury, crises, or care transitions, as defined below.
   Specific personal emergencies may include:
   a. Serious illness or injury - The illness or injury is preventing the member from receiving CBAS within the facility and providing medically necessary services and supports that are required to protect life, address or prevent significant illness or disability, and/or alleviate pain.
   b. Crises – The member is experiencing, or threatened with, intense difficulty, trouble, or danger. Examples of personal crises include the

sudden loss of a caregiver, neglect or abuse, loss of housing, etc.

c. Care transitions – Transitions to or from care settings, such as returning to the home or another community setting from a nursing facility or hospital. ERS provided during care transitions should address service gaps and the member/caregiver needs and not duplicate responsibilities assigned to the intake or discharging entities.

Members may choose to cease receipt of ERS at any time. The Alliance will cover ERS as part of the CBAS benefit when a member meets the criteria established as outlined above.

### *SERVICES FOR MEMBERS WITH DEVELOPMENTAL DISABILITIES*

**Developmental Disability Referrals**
The Alliance coordinates referrals to the Regional Center of the East Bay (Regional Center) for members with developmental disabilities.

**Referral Guidelines**
Providers or family members may refer directly to the Regional Center. The family must make the intake appointment with the Regional Center. Prior authorization is not required.

Providers must:

- Document the referral to the Regional Center in the member's medical record; and
- Provide necessary medical evaluations and obtain written consent prior to releasing any medical information directly to the Regional Center.

For more information, please contact:

Regional Center of the East Bay
Creekside Plaza
500 Davis Street, Suite 100
San Leandro, CA 94577
Phone Number: **1.510.618.6100**
Fax: **1.510.678.4100**

## Transgender Services (Health Care Services)

The Alliance covers medically necessary care for transgender members, consistent with the state Medi-Cal benefit APL 20-018, and following the World Professional Association of Transgender Health (WPATH) Standard of Care for Gender Dysphoria. All services require prior authorization.

Examples of services may include:

1. Gender confirmation surgery, including facial feminization surgery

2. Hair removal services
3. Hormone therapy for adults over 18 years of age
4. Hormone therapy or pubertal suppression for children under 18 years of age
5. Reconstructive surgery
6. Voice/communication therapy services related to transgender care
7. Voice feminization/modification surgery

State law defines "medically necessary" as follows:

1. For Medi-Cal members **21 years of age** or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. (Welfare and Institutions Code section 14059.5.)
2. For Medi-Cal members under **21 years of age**, a service is "medically necessary" or a "medical necessity" if the service corrects or ameliorates defects and physical and mental illnesses and conditions. (Title 42 USC 1396d(r)(5).)
3. For Group Care members, "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
    i. In accordance with the generally accepted standards of mental health and substance use disorder care.
    ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.
    iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider (HSC 1374.72(a)(3)(A)).

Gender dysphoria (defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5) is treated with the following core services:

1. Behavioral health services
2. Hormone therapy
3. Psychotherapy
4. Surgical procedures that bring primary and secondary gender characteristics into conformity with the individual's identified gender

## Tertiary and Quaternary (TQ) Services (Health Care Services)

The Alliance requires prior authorization for referrals and transitions to tertiary and quaternary (TQ) academic centers to ensure that members are accessing the right level of care at the right time for efficient and expedient access to services. All physician-based services (office visits and consultations) to a TQ center require prior authorization (initial and ongoing). To minimize the need for ongoing submission, please follow the Standing Referral process. The prior authorization process will make certain that a standardized

process is utilized in reviewing the appropriateness of referrals and transitions to TQ centers. This will establish consistency of all reviews, both internally and externally (delegates, hospitals, clinics), resulting in highly specialized care prevention that will impact illness and restore health to the highest physical or psychological function. The Alliance makes utilization management decisions only on the appropriateness of care and the existence of coverage. The Alliance maintains a network of providers that is sufficient to provide adequate access to care.

TQ care referrals may be appropriate in the following situations:

- When a higher level of care in the form of a specialized diagnostic approach, treatment, and/or procedure is warranted.
- When a member is new to the Alliance (within the last **12 months**) and has been receiving acute care management from a TQ-level provider.
- When redirection may result in the delay of necessary medical treatment.
- Referrals to secondary sub-specialists when the member is being managed for a primary diagnosis to allow for multi-disciplinary collaboration for the member's overall plan of care.
- Services not available in the community or of limited availability.
- Ancillary requests (radiology, lab, etc.) may be considered to prevent potential delays in treatment decisions.

The information below should be included along with the PA request:

- Indicate the reason(s) why the member requires tertiary-level service
- Primary diagnosis driving TQ-level care
- Any information or records from community specialists
- Plan of care if applicable
- Anticipated length of treatment

All other services that currently require prior authorization will remain the same. For delegated members, the PA request will be submitted to the delegated medical group.

## Second Opinions (Health Care Services)

PCPs, specialists, and members (if the practitioner refuses) have the right to request a second opinion from a qualified health professional, at no cost to the member, from the Alliance regarding proposed medical or surgical treatments from an appropriately qualified participating health care professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition, or conditions associated with the request for a second opinion.

Second opinions from contracted providers do not require authorization and are arranged through the member's assigned PCP.

The Alliance provides a second opinion from a qualified health care professional in the network or arranges for the member to obtain one out of network, at no cost to the

member.

A prior authorization from the Alliance is required to receive a second opinion from an out-of-network provider. The time frames for processing second opinions follow the standard authorization time frames.

The second opinion authorization or denial shall be provided expeditiously appropriate to the member's condition, not to exceed 72 hours after the Alliance's receipt of the request.

## Coordination of Care (Health Care Services)

The Alliance provides comprehensive medical case management to all members. Comprehensive medical case management includes care coordination for medically necessary services provided to members within and outside of the Alliance's provider network based on the individual member's needs.

### *PRIMARY CARE PROVIDER (PCP) ROLE*

Continuity and coordination of care are ensured through the PCP who is formally designated as having primary responsibility for coordinating the member's overall health care. The PCP has the responsibility and authority to direct and coordinate the member's services.

These responsibilities include:

1. Act as the primary case manager for all assigned members
2. Assess the acute, chronic, and preventive needs of each member
3. Employ disease management protocols to manage a member's chronic health conditions.

### *DELIVERY OF PRIMARY CARE*

The establishment of an ongoing relationship between the member and their chosen PCP is crucial to the member achieving optimal health. Members are encouraged to make an appointment with their PCP immediately upon selection of their PCP. Primary care services will be available according to the health plan's established access and availability standards.

## Coordination of Services (Health Care Services)

The PCP has primary responsibility for evaluating the member's needs before recommending and arranging the services required by the member and facilitating communication and information exchange among the different providers/ practitioners treating the member.

Members are included in the planning and implementation of their care, with special

emphasis on those members with mental health or substance use problems, co-existing conditions, and chronic illnesses, or those members at the end of life. Members who are unable to fully participate in their treatment decisions (i.e., minors, incapacitated adults) may be represented by parents, guardians, other family members, or conservators, as appropriate, and in accordance with the member's wishes.

The Alliance offers care coordination for the following services:

- Alcohol and substance use disorder treatment services
- Behavioral health care
- California Children's Services (CCS)
- Children with special health care needs
- Dental services
- Directly observed therapy (DOT) for the treatment of tuberculosis (TB)
- Early intervention service with the Early Start Program
- Emergency department (ED) follow-up
- Excluded services requiring member disenrollment
- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver program
- Local Education Agency services (LEA)
- Services for persons with developmental disabilities (Regional Center)
- Services with out-of-network providers
- Waiver Program
- Women, Infants, and Children (WIC) Supplemental Nutrition Program

### *ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES*

PCPs are responsible for identifying members with active or potential substance use problems. Once members are identified, PCPs are responsible for providing services for the substance use problem within their scope of practice (counseling and/or treatment) and for performing the appropriate medical workup given the nature of the substance use problem. PCPs are also responsible, with the assistance of the Alliance, for referring members with substance use problems to an appropriate treatment practitioner or county department.

### *BEHAVIORAL HEALTH CARE*

The Alliance collaborates with its behavioral health providers to identify opportunities to improve the coordination of behavioral health care with general medical care that may include but is not limited to collaboration between the organization and behavioral health providers. Behavioral health care coordination is provided by the Alliance Behavioral Health Care Department. For more information, please visit the Alliance website at **www.alamedaalliance.org**.

### *CALIFORNIA CHILDREN'S SERVICES (CCS)*

PCPs and specialists are responsible for the early identification of members who may

have eligible CCS conditions. Medically necessary health care services will be administered throughout the referral process with the Alliance, regardless of whether the child is accepted into the CCS Program (e.g., Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medi-Cal members). The Alliance will consult and coordinate CCS referral activities with the local CCS Program in accordance with the MOU.

### *CHILDREN WITH SPECIAL HEALTH CARE NEEDS*

The Alliance will assist with referrals/authorizations and care coordination to ensure that members receive the care appropriate for their medical, mental, or physical condition.

### *DENTAL SERVICES*

Dental services are not covered by Medi-Cal managed care. However, the Alliance will ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.

### *DIRECT OBSERVED THERAPY (DOT) FOR TREATMENT OF TUBERCULOSIS (TB)*

DOT is offered by the local health departments (LHDs) and is not covered by Medi-Cal managed care. PCPs will assess the risk of non-compliance with drug therapy for each member who requires placement on anti-tuberculosis therapy.

### *EARLY INTERVENTION SERVICE WITH THE EARLY START PROGRAM*

PCPs are responsible for assessing children's developmental status during well-child exams or at other medical encounters as appropriate. Children from birth to 36 months identified at risk for or suspected of having a developmental disability or delay must be referred to the Regional Center of the East Bay (RCEB) for evaluation for the Early Start Program. The Alliance will collaborate with RCEB or the local Early Start Program in determining the medically necessary diagnostic and preventive services and treatment plans for members participating in the Early Start Program.

### *EXCLUDED SERVICES REQUIRING MEMBER DISENROLLMENT*

For services related to incarceration, the Alliance will initiate the disenrollment process.

### *HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME (HIV/AIDS) WAIVER PROGRAM*

Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered by Medi-Cal managed care. However, contracted PCPs and specialists (practitioners) have the responsibility to identify and refer Medi-Cal managed care members to an HIV/AIDS waiver program if they meet the criteria.

### *LOCAL EDUCATION AGENCY SERVICES (LEA)*

Services provided by Local Education Agencies (LEA) as called for in the LEA's Individual Education Plan (IEP) are not covered benefits under Medi-Cal managed care benefit. In compliance with the Children and Youth Behavioral Health Initiative (CYBHI), the Alliance will cover behavioral health services provided by school-based providers who are approved to provide mental health services under the CYBHI program. On an as-needed basis, the Alliance will work with the PCP to coordinate care for a member to ensure the provision of all medically necessary covered diagnostic, preventive, and treatment services identified in the Individual Education Program (IEP) developed by the LEA, with the PCP's participation. The Alliance is working in collaboration with LEAs to expand behavioral health care services in and near schools.

### *SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (REGIONAL CENTER)*

Contracted PCPs and specialists (practitioners) are responsible for the identification and referral of members with developmental disabilities/ behavioral health disorders outside their scope of practice. The Alliance implements and maintains systems to identify members with developmental disabilities who may meet requirements for Regional Center Services.

### *SERVICES WITH OUT-OF-NETWORK PROVIDERS*

The Alliance identifies members who may need or who are receiving services from out-of-network (non-contracted) providers and/or programs to ensure coordinated service delivery and efficient and effective joint case management.

### *WAIVER PROGRAM*

Members who may qualify for one (1) of the Waiver Programs will be identified by their PCP, with Alliance UM Department support, based on their diagnosis and need for a specific level of care. Authorization of services should be medically necessary and recommended by the PCP or the specialty care provider (SCP). Members have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP. Members who may qualify for one of the Waiver Programs can be identified by their PCP, the Alliance Case Management Department, or Alliance Utilization Management Department based on the member's diagnosis and need for a specific level of care. Authorization of services should be medically necessary and recommended by the PCP or specialty care provider (SCP). Members have a right to request any covered services, whether or not the service has been recommended by the PCP/SCP. The authorization for services must be approved through a utilization management system (either the health plan or the delegated medical group/IPA) based on medical necessity.

### *WOMEN, INFANTS, AND CHILDREN (WIC) SUPPLEMENTAL NUTRITION PROGRAM*

The Alliance PCP, obstetrical (OB), and pediatric practitioners will inform members of the availability of Women, Infants, and Children (WIC) services and make appropriate referrals to the local WIC program for their assigned members who are potentially eligible

for WIC services.

## Coordination of Care – California Children's Services (CCS) (Health Care Services)

PCPs and specialists are responsible for:

1. Early identification and referral of children with potentially eligible conditions to California Children's Services (CCS).
2. Notifying the Alliance Utilization Management (UM) Department of members referred to CCS.
3. Administering medically necessary health care throughout the referral process, with the Alliance, regardless of whether or not the child is accepted into CCS. For example, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for Medi-Cal members.

CCS is responsible for:

1. Treatment for CCS-eligible conditions.
2. Reimbursement of CCS-paneled providers and CCS-approved hospitals.
3. Covering EPSDT services related to the CCS condition for Medi-Cal members.

# Section 7: Behavioral Health Services

## ***MEDI-CAL MENTAL HEALTH SERVICES***

Medi-Cal members can access mental health care in two ways:

- through Alameda County Behavioral Health (ACBH) for severe conditions or
- through the Alliance for mild-to-moderate conditions.

Medi-Cal members with severe mental health needs receive what are called "specialty mental health services" (SMSHS). On the other hand, the Alliance offers "non-specialty mental health services" (NSMH) to Medi-Cal members with mild to moderate mental health needs.

Medi-Cal members are screened using a Department of Health Care Services (DHCS) tool to determine which system of care they will receive services. https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

The screening is completed by the Alameda County Behavioral Health (ACBH) ACCESS or the Alliance. Providers are not required to complete the screening.

If a member currently in mental health treatment requires a higher level of care beyond outpatient visits, providers should complete the DHCS required transition of care form. <insert link> This form can be forwarded directly to ACBH ACCESS.

## ***MEDI-CAL: SPECIALTY MENTAL HEALTH SERVICES (SMHS)***

Medi-Cal members are eligible to receive specialty mental health services (SMHS) from the Alameda County Behavioral Health (ACBH). SMHS services are services focused on treating severe conditions that require treatment beyond outpatient visits.

Providers may also contact ACCESS for urgent conditions to receive a triaged consultation. For crisis resources available in Alameda County see https://www.crisissupport.org/get-help-now/alameda-county-crisis-referrals/prompt intervention is certain to result in an immediate emergency psychiatric condition.

These referrals can be made 24 hours a day, 7 days a week, by calling the ACCESS helpline for Medi-Cal members:

Phone Number: **1.510.346.1000**

Toll-Free: **1.800.491.9099**

If a member's mental disorder is outside the scope of the provider's practice, or requires a higher level of care beyond outpatient visits, the provider may also refer the Medi-Cal member to specialty mental health care by calling ACCESS and completing the Department of Mental Health Services (DHCS) required transition of care form which can be accessed here, Transition of Care Tool for Medi-Cal Mental Health Services.

ACBH ACCESS serves all ages. Medi-Cal members seeking mental health services for themselves or their minor children may directly access specialty mental health care by calling ACCESS. The county will provide consultations by phone to Alliance PCPs. Consultations are available Monday – Friday, 8 am – 5 pm, through the ACCESS helpline.

### *MEDI-CAL: NON-SPECIALTY MENTAL HEALTH SERVICES (NSMH)*

Alliance Medi-Cal members are eligible for NSMH services with Alliance Network Providers in the following situations:

The members screens as mild to moderate based on the DHCS mental health screening tool (score less than 6) or

- The member is receiving SMHS, but the outpatient services is not available within SMHS.

The Alliance covers the following medically necessary non-specialty mental health services:

- Dyadic therapy
- Family therapy
- Group therapy
- Individual therapy
- Psychiatric consultation and medical management
- Neuropsychological and Psychological testing
- Transcranial Magnetic Stimulation
- Spravato

**Prior Authorization for NSMH – Alliance Provider Network**

No prior authorization is required for an initial mental health evaluation and ongoing outpatient visits with contracted mental health providers.

Prior authorization is required for the following outpatient services:

- Psychological/neuropsychological testing,
- Transcranial magnetic stimulation (TMS)
- Outpatient electroconvulsive therapy (ECT),
- ketamine/Spravato drug treatment.

All prior authorization requests may be submitted with supporting clinical documentation demonstrating medical necessity.

Intensive outpatient, partial hospitalization and inpatient care is not a covered benefit under the NSMH benefit through the Alliance. However, comparable services are available to members via the SMHS offered by ACBH.

If a member's mental disorder is outside the scope of the provider's practice, or requires a higher level of care beyond outpatient visits, the provider may also refer the Medi-Cal member to specialty mental health care by calling ACCESS and completing the Department of Mental Health Services (DHCS) required transition of care form which can be accessed here, Transition of Care Tool for Medi-Cal Mental Health Services.

**GROUP CARE MEMBERS – MENTAL HEALTH AND SUBSTANCE USE DISORDERS**

For Group Care members, the Alliance offers a non-exhaustive list of behavioral health care services that evaluate and treat mental health and substance use disorders regardless of severity. ,

Prior authorization is not required for routine outpatient behavioral health care services with contracted Alliance providers. Members can self-refer to most services.

Prior authorization is required for medically necessary higher levels of care beyond outpatient services such as intensive outpatient programs (IOP), residential treatment and inpatient psychiatric treatment. In addition, the following outpatient services require prior authorization:

- Psychological/neuropsychological testing,
- Transcranial magnetic stimulation (TMS)
- Outpatient electroconvulsive therapy (ECT),

- Spravato drug treatment.

All prior authorization requests must be submitted with supporting clinical documentation demonstrating medical necessity.

### *SUBSTANCE USE TREATMENT SERVICES*

**For Medi-Cal members,** all substance use treatment is managed by ACBH ACCESS.

| SUBSTANCE USE TREATMENT SERVICES |
|---|
| **Medi-Cal Members** |
| Alameda County Behavioral Health Plan (ACCESS) Helpline |
| Phone Number: **1.510.346.1000** |
| Toll-Free: **1.800.491.9099** |
| **Alliance Group Care Members** |
| Alliance Member Services Department |
| Phone Number: **1.510.747.4567** |
| Toll-Free: **1.877.932.2738** |

**For Group Care members,** the Alliance covers a non-exhaustive list of medically necessary substance use treatments.

For Group Care members in need of substance use disorder treatment, prior authorization is required for the following substance use services;

- Psychological/neuropsychological testing,
- Transcranial magnetic stimulation (TMS)
- Outpatient electroconvulsive therapy (ECT)
- Spravato drug treatment
- Residential
- Intensive Outpatient Program

- Partial Hospitalization Program.

# Behavioral Health Evaluation and Treatment for Autism for Members Under Age 21 years

## PCP REFERRAL REQUIREMENTS FOR ABA OR COMPREHENSIVE DIAGNOSTIC EVALUATION (CDE)

Members who may need an autism evaluation can be referred by completing the Alliance Behavioral Health (BH) Care – Autism Evaluation, BHT/ABA Referral Form. To access the form, please visit the Alliance website at www.alamedaalliance.org/providers/provider-forms.

Below are sample scenarios to determine the next steps for referrals.

| SCENARIO #1 | SCENARIO #2 | SCENARIO #3 |
|---|---|---|
| a. You or a member's family suspects the member has autism.<br>b. The member has never had a psychological assessment to rule out autism, there are behavioral health concerns, and you are unsure of what type of BHT member may need (ABA or other types of BHT). | a. You determine that other behavioral health or mental health services may be medically necessary (you are not recommending ABA either due to lack of supporting documentation or ABA is not clinically indicated). | a. You have conducted your own assessment/screening, are familiar with ABA treatment, and deem that the member can benefit from ABA treatment.<br>b. A licensed psychologist has diagnosed the member with autism or another diagnosis, and you deem that a referral for ABA treatment is medically necessary. |
| ⇩ | ⇩ | ⇩ |
| **Refer for Diagnostic Evaluation**<br>A diagnostic evaluation for autism is administered by a licensed psychologist. This assessment is conducted to rule out autism (evaluation of child/adolescent with indications from screening of possible autism but no formal diagnosis has been given). It will either yield a diagnosis of autism or not and will provide recommendations as needed. | **Next Steps: Referral for Mental Health**<br>Mental health services include all evidence-based services for the treatment of mental and/or substance use disorders that may include depression, post-traumatic stress, anxiety disorders, phobias, ADHD, mood disorders, attachment disorders, and more.<br>Treatments may include individual and group | **Next Steps: Referral for ABA**<br>ABA treatment is a specific type of behavioral health treatment that addresses socially significant behaviors (e.g., maladaptive behaviors, social interactions, communication, and self-help skills) through the application of behavioral strategies. ABA was first implemented with individuals with autism and intellectual disability; therefore, empirical research has mostly been concentrated on efficacy with these populations.<br>Please complete the Behavioral Health |

| | | |
|---|---|---|
| Please complete the Behavioral Health (BH) Care – Autism Evaluation, BHD/ABA Referral Form, and check the box for **Diagnostic Evaluation/ Psychological Assessment to rule out autism**. | counseling, medication, and other supportive services.<br><br>Please complete and submit the Behavioral Health (BH) Care Referral Request Form. | (BH) Care – Autism Evaluation, BHD/ABA Referral Form, and check the box for **Applied Behavioral Analysis (ABA) Treatment**" and complete Section 4: Evaluation/ Referral Information within the form.<br><br>**If the PCP has information regarding the member or family's availability for services (times of day and days of the week), please include it in Section 5: Additional Information.** |

### *AUTHORIZATION REQUIREMENTS FOR ABA*

Members must have a recommendation for ABA treatment from a licensed physician or licensed psychologist. Medi-Cal embers must also meet the criteria outlined in the California Department of Health Care Services (DHCS) All Plan Letter 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

The Alliance Behavioral Health team will help link members to ABA providers for the initial assessment. Members can also seek out preferred in-network providers once they obtain a referral from a licensed physician/licensed psychologist. ABA providers can also submit a prior authorization (PA) request for the initial ABA assessment/Functional Behavioral Assessment (FBA) if they have the member's referral/recommendation from a licensed physician/licensed psychologist.

The initial assessments/FBA with all treatment plan elements and requests for authorization must be submitted through our Provider Portal. For more information, please refer to the most current Applied Behavior Analysis (ABA) Treatment Plan (TP) Report Guidelines for Providers. These can be found on the provider portal, or in the provider section of The Alliance's website.

### *RE-AUTHORIZATION REQUIREMENTS FOR ABA*

All PA requests and treatment plans for the continuation of ABA treatment must be submitted through our Provider Portal.

The treatment plans must contain all of the following elements as required by DHCS:

1. Description of patient information, the reason for referral, brief background information (e.g., demographics, living situation, or home/school/ work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
2. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
3. Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.

4. Include outcome measurement assessment criteria that will be used to measure the achievement of behavior objectives.
5. The member's current level of need (baseline, expected behaviors the guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria (the objective goal), date of introduction, estimated date of mastery, specify a plan for generalization and report goal as met, not met, or modified (include explanation).

   Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.

6. Clearly identify the service type, number of hours of direct service(s), observation and direction, guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual provider who is responsible for delivering services.
7. Include care coordination that involves the guardian, school, state disability programs, and other programs and institutions, as applicable.
8. Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision. However, MCPs must not reduce the number of medically necessary BHT hours that a member is determined to need by the hours the member spends at school or participating in other activities.
9. Deliver BHT services in a home or community-based setting, including clinics. BHT intervention services provided in schools, in the home, or in other community settings, must be clinically indicated, medically necessary, and delivered in the most appropriate setting for the direct benefit of the member. BHT service hours delivered across settings, including during school, must be proportionate to the member's medical need for BHT services in each setting.
10. Include an exit plan/criteria. However, only a determination that services are no longer medically necessary under the EPSDT standard can be used to reduce or eliminate services.

To avoid a lapse in treatment and backdating of authorizations, please submit the updated treatment plan/progress report two (2) weeks before the current ABA treatment authorization ends.

**PLEASE NOTE:** ABA treatment requires prior authorization before services are rendered. Providers must have an approved authorization for the dates of service as indicated in the PA request.

### *ABA PROCEDURE CODE AND UNITS*

For each procedure code, please enter the total number of units for the authorization period (e.g., 6 months). The number of units must be in whole numbers.

To convert the total number of treatment hours for the 6 months to units, please use the following formula:

Total number (#) of hours for 6 months **x** 4 units = Total # of units (for the authorization period)

**Example**: If requesting 100 total hours of H2019, it would be submitted as:

100 **x** 4 = 400 units.

To convert the number of hours per week to the total number of units for the 6-month authorization period, please use the following formula:

Number of hours per week **x** 26 (weeks) **x** 4 (units) = Total # of units (for the authorization period)

**Example**: If requesting 10 hours per week of H2109, it would be submitted as:

10 **x** 26 **x** 4 = 1,040 units

***PROCEDURE CODES AND DESCRIPTIONS FOR ABA TREATMENT***

**H0031** – Behavior identification assessment. This will be utilized for the initial assessment/FBA and treatment plan development.

**H0032** – Observational behavioral follow-up assessment. This will be included in the initial ABA services authorization letter and will be utilized for the progress report and re-assessment.

**H2012** – Adaptive behavior treatment with protocol modification. This will be utilized for program supervision (direct and indirect).

Examples of direct and indirect supervision activities:

| DIRECT SUPERVISION | INDIRECT SUPERVISION |
|---|---|
| Directly observe treatment implementation to determine if any changes are needed. Sometimes treatment plans need to be modified more frequently. | Analyze and summarize direct observation data to evaluate the member's progress toward goals. Typically done weekly (depending on member's needs/response to treatment). |
| Provide direction/guidance to staff and/or caregivers in the implementation of the treatment plan (with the member present). Typically done during treatment sessions. | Engage in care coordination with other service providers. |
| Observe and monitor treatment reliability to ensure implementation of treatment plan/protocols by behavior interventionist (BI)/staff. This will be | • Develop treatment plans and data collection systems.<br>• Develop transition/discharge plans.<br>• Make adjustments/revise treatment |

| | |
|---|---|
| important if there are staff changes or revisions to a member's treatment plan. | plans and protocols. |

**H2019** – Adaptive behavior treatment with one (1) patient. This is utilized for direct/1:1 ABA services provided to the member (member must be present).

**H2014** – Adaptive behavior treatment social skills group with multiple patients. This is utilized for social skills groups with members and other peers. Typically, there are four (4) children/clients/members to one (1) adult/provider in the group setting.

**S5111** – Family adaptive behavior treatment guidance. This is utilized for parent/caregiver training targeting parent/caregiver goals.

# Section 8: Claims

## Claims Overview (Claims)

### *CLAIM REQUIREMENTS*

The Alliance has established requirements for filing a claim for payment consideration. These requirements include that the claim is valid and complete, furnished within a prescribed time, and delivered to the correct business address. Failure to comply with these requirements may jeopardize the claim for reimbursement.

To be accepted as a valid claim, the submission must meet the following criteria:

- Must be submitted on a standard current version of a CMS 1500, CMS-1450 (UB04), or the ANSI X12-837-5010 (current version electronic format).
- Must contain appropriate information in all required fields.
- Must be a claim for an Alliance member eligible at the time of service. (Always verify eligibility; for more information, please refer to "How to verify eligibility" in Section 3: Eligibility and PCP Choice).
- Must be an original bill.
- Must contain correct national standard coding, including but not limited to CPT, HCPCS, NDC (as published by the Food and Drug Administration (FDA), Revenue, and ICD-10 codes.
- Must not be altered by handwritten additions to procedure codes and/or charges.
- Must be signed by the rendering provider if paper.
- Must be printed with a dark ink that is heavy enough to be electronically imaged, if submitted as a paper claim.
- Must be received within **180 days** from the service date for contracted providers and **365 days** for non-participating (non-contracted) providers.
- Must submit attachments on an 8 ½ x 11-inch sheet of paper and be legible.

## Submitting a Claim (Claims)

### *HEALTH INSURANCE CLAIM FORM (CMS 1500) – PROFESSIONAL CLAIMS*

The Centers for Medicaid and Medicare Services (CMS) form 1500 must be used to bill the Alliance for medical services. This form is used by physicians and allied health professionals to submit claims for medical services.

### *HEALTH INSURANCE CLAIM FORM (CMS 1450) – FACILITY CLAIMS*

A CMS 1450 (UB-04) is the only acceptable claim form for submitting inpatient or outpatient hospital (technical services only) charges for reimbursement by the Alliance. In addition, a CMS 1450 is required when billing for nursing home services, swing bed services with revenue and occurrence codes, inpatient hospice services, Ambulatory Surgery Centers (ASC), and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected or denied for corrections.

ALAMEDA Alliance FOR HEALTH

***PAPER CLAIMS SUBMISSION***

Paper claims for Alliance members should be submitted for payment as follows:

| CLAIM TYPE | RESPONSIBLE ENTITY |
|---|---|
| **Professional Medical Service Claims** | If the member/patient is assigned to an **Alliance PCP**:<br>Alameda Alliance for Health<br>PO Box 2460<br>Alameda, CA 94501-0460<br><br>If the member/patient is assigned to a **CHCN PCP**:<br>Community Health Center Network<br>101 Callan Ave., 3rd Floor<br>San Leandro, CA 94577<br><br>If the member/patient is assigned to a **CFMG PCP**:<br>Children's First Medical Group<br>PO Box 99680<br>Emeryville, CA 94662-9680 |
| **Institutional (Hospital, SNF, Long-Term-Care, etc.) Services Claims** | Hospital/facility claims for all Alliance members:<br>Alameda Alliance for Health<br>PO Box 2460<br>Alameda, CA 94501-0460 |
| **Behavioral Health Claims (Includes mental health and applied behavioral analysis)** | For **Medi-Cal members** and if the services are moderate-to-severe, such as specialty mental health and severe mental illness:<br>ACCESS, Alameda County Behavioral Health Care Services<br>Toll-Free: **1.800.491.9099**<br><br>For **Medi-Cal members** and if the services are mild-to-moderate:<br>Alameda Alliance for Health<br>PO Box 2460<br>Alameda, CA 94501-0460<br><br>For **Group Care members**:<br>Alameda Alliance for Health<br>PO Box 2460<br>Alameda, CA 94501-0460 |
| **Vision Claims** | Medi-Cal members:<br>MARCH Vision Care<br>Attn: Claims Department<br>6701 Center Drive West, Suite 790<br>Los Angeles, CA 90045<br>**www.marchvisioncare.com** |

| CLAIM TYPE | RESPONSIBLE ENTITY |
|---|---|
| **Dental Claims** | Medi-Cal members:<br>Medi-Cal Dental<br>California Medi-Cal Dental Program<br>PO Box 15609<br>Sacramento, CA 95852-0609 |

### *ELECTRONIC CLAIMS SUBMISSION*

The Alliance offers providers the speed, convenience, and lower administrative costs of electronic claims filing, also known as Electronic Data Interchange (EDI). Providers interested in submitting claims electronically should call the Alliance Provider Services Department at **1.510.747.4510**.

Claims that require attachments may not be sent electronically. They must be submitted using the appropriate paper claim forms with the attachments.

### *TIME FRAME FOR CLAIMS SUBMISSION*

All claims must be submitted on time for consideration of payment. Claims submitted after the appropriate filing deadline will be denied unless documentation substantiating the delay in billing is provided. Claims submitted prior to the actual date of service (or date of delivery for supplies and DME) will also be denied.

Timely filing rules are as follows:

- When the Alliance is the primary payer on the claim:
- Participating (contracted) providers must submit claims post-service within the timely filing time frame identified in your agreement with the Alliance. Post-service is defined as after the date of service for professional or outpatient institutional providers, or after the date of discharge for inpatient institutional providers.
- Unless otherwise indicated in your agreement, contracted providers must submit claims within **180 calendar days** post-service.
- Non-participating (non-contracted) providers must submit claims within **365 calendar days** post-service.
- When the Alliance is not the primary payer under Coordination of Benefits (COB):
- Providers must submit a claim to the Alliance within **180 days** from the date of payment or date of denial notice from the primary payer.
- Providers must also submit a copy of the Remittance Advice (RA)/ Explanation of Benefits (EOB) from the primary payer which indicates the date of resolution by the primary payer, whether paid, contested, or denied.
- When an Alliance member does not present accurate insurance information, and another payer or the member is billed for the service:
- The provider must submit a claim to the Alliance within **60 days** of receiving the correct insurance information from the member or incorrect payer.

- The provider must also submit proof that the member or another payer has been billed.
- Claims or any portion thereof previously denied by the Alliance as an incomplete claim due to missing or invalid information:
- A corrected claim must be submitted for reconsideration of payment within **180 days** from the date of the original denial by the Alliance. A corrected claim may be mistaken as a duplicate claim submission unless it is clearly identified as such.

### *CLAIMS STATUS AND INQUIRY*

Claim status can be verified for providers using our Online Provider Portal. Contact the Alliance Provider Services Department at **1.510.747.4510** for information regarding the use and how to obtain a Provider Portal account if you do not already have one.

Providers should call the Alliance Provider Services Department at **1.510.747.4510** for more complex claim status questions or submission requirements. Alliance Provider Services Representatives can assist with the resolution of complex claims issues and arrange for the adjustment of claims, if necessary.

### *PROOF OF TIMELY FILING*

If a claim has been denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- RA/EOB from the primary carrier
- Copy of enrollment card presented at time of service

### *MISDIRECTED CLAIMS*

When a claim is incorrectly sent to the Alliance that should have been sent to one of its delegated partners (e.g., CHCN, CFMG, etc.), the Alliance will forward the claim to the appropriate delegated partner within **10 working days** of receipt of the claim.

The provider will also receive a notice of denial with instructions to bill the delegated partner.

## Claims Receipt and Determinations (Claims)

### *ACKNOWLEDGEMENT OF CLAIM RECEIPT*

The Alliance will acknowledge the receipt of an electronic claim within **2 working days** from receipt of the claim or within **15 working days** of receipt of the claim if it was submitted on paper.

### *CLEAN CLAIM*

A clean claim is defined as a claim that, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation

needed to determine payer liability and make timely payment.

### *CLEAN CLAIM PROCESSING TIME*

The Alliance will adhere to the following claims processing guidelines:

- 90% of clean claims within **30 calendar days** from receipt
- 95% of clean claims within **45 working days** from receipt
- 99% of clean claims within **90 calendar days** from receipt

### *INTEREST ON CLAIMS*

The Alliance will calculate and automatically pay interest, in accordance with Assembly Bill (AB) 1455 requirements, to all providers of service who have not been reimbursed for payment, within **45 working days** after the receipt of a clean claim.

### *BILLING MEMBERS*

Providers are prohibited from billing Alliance members for covered services. Under the Knox-Keene Act, Health and Safety Code 1379 of the State of California, it is illegal to bill a member who is enrolled in a state program for which services were provided. Alliance members are never responsible for paying participating providers any amount for covered medical services, other than approved co-insurance, deductibles, or co-payment amounts as a part of the member's benefit package.

Providers may not seek reimbursement from the member for a balance due. Providers may not bill Alliance members for covered services, open bills, or balances in any circumstance, including when the Alliance has denied payment. In some cases, providers may bill members for co-payments, non-benefits, and non-covered services.

### *OVERPAYMENTS AND RECOUPMENTS*

Overpayments can happen for many reasons, including, but not limited to:

- Alliance claim processing error
- Another party paid for covered services (i.e., coordination of benefits)
- Duplicate payment made by the Alliance when covered services are payable, in part or full, to another provider
- Retroactive change to eligibility

A written overpayment request will be sent to the provider within **365 days** of the date the original claim was paid. The provider must either dispute or refund the requested monies within **30 working days** from receipt of the notification of overpayment. If the provider does not dispute or refund the requested monies within **30 working days**, the Alliance may offset the requested amount against future claim payments, as documented in the contractual agreement or when a non-contracted provider has agreed in writing.

**COORDINATION OF BENEFITS (COB)** is used to determine the order of payment responsibility when an Alliance member is covered by more than one (1) health plan or insurer. The Alliance is always the payer of last resort for Medi-Cal members and all other

coverage is primary. State and federal laws require providers to bill other health insurers prior to billing the Alliance.

### *COORDINATING BENEFITS*

All claims must be submitted to the Alliance within **180 days** from the date of payment on the primary payer's RA/EOB. A copy of the RA/EOB must accompany the claim. If the primary payer denies services asking for additional information, the information must be submitted to the primary payer and the claim finalized prior to submitting the claim to the Alliance. Since a copy of the primary payer's RA/EOB must be submitted along with the claim, these claims must be submitted on paper. Claims submitted electronically where the member has other coverage will be denied with instructions to resubmit as a paper claim with the RA/EOB attached.

When the Alliance is the primary payer, providers are reimbursed at their full contracted reimbursement rate or based on Medi-Cal rates for non-participating (non-contracted) providers.

When the Alliance is the secondary payer under COB rules, the Alliance will generally pay the lesser of the following amounts for covered services:

- The actual charge made by the provider less the amount paid by the other coverage up to the patient responsibility portion (co-insurance, deductible, or co-pay amounts).
- Up to the amount the Alliance would have paid if the individual did not have other coverage.

If the primary insurance payment exceeds the fully allowed contracted rate, neither the Alliance nor its member is financially responsible for any additional amount.

### *THIRD-PARTY LIABILITY*

Providers may often learn of a possible Third Party Liability (TPL) case before the Alliance. Therefore, providers must assist with recovery by promptly notifying the Alliance when a TPL case is discovered.

Notification and TPL information may be either mailed or faxed to:

Alameda Alliance for Health
Claims Department
PO Box 2460
Alameda, CA 94502-0460
Fax: **1.877.747.4506**

Providers must promptly notify the Alliance Claims Department of a TPL case when:

- The patient has filed or intends to file a claim or lawsuit against a third party for injuries
- A third party that caused or allegedly caused the patient's injury has insurance

that will cover the expenses

Below are some situations where a possible TPL case may exist:

- Member involved in an auto accident
- Member injured on premises owned by another (e.g., slip-and-fall)
- Member injured on the job (worker's compensation)
- Member injured by another's negligence

### *TPL SUBMISSION REQUIREMENTS*

When a TPL case is identified, the provider's staff should obtain the following information from the member and forward it with the TPL Notification Form to the Alliance:

- Patient name, social security number, address, and telephone
- Date of injury
- Attorney's name, address, and telephone number (if any)
- Third party's insurance carrier or attorney's name, address, and telephone number (if known)

## Service Specific Information (Claims)

### *AMBULANCE, EMERGENCY, URGENTLY NEEDED, AND POST-STABILIZATION CARE SERVICES*

The Alliance is responsible for ambulance, emergency, urgent, and post-stabilization care services, whether services are obtained in or out of network.

During Business Hours: A contracted or non-contracted hospital can call the Alliance Authorization Unit when the hospital determines that a member is stable for transfer or to obtain authorization for post-stabilization care. The hospital only needs to make one (1) call to the Alliance to request prior authorization for post-stabilization care. If the Alliance does not respond to the request within one-half hour (30 minutes), the post-stabilization care shall be deemed as approved. The Alliance Authorization Unit coordinator will confirm the member's eligibility and forward the information to an Alliance Utilization Management (UM) nurse. The Alliance UM nurse will perform a telephonic review of the member's current medical conditions and coordinate any necessary post-stabilization care.

To contact the Alliance Authorization Unit, please call:

Alliance Authorization Unit

Phone Number: 1.510.747.4540

Toll-Free: 1.855.891.9161

After Business Hours, Weekends, and Holidays: Contracted and non-contracted hospitals

can call the Alliance On-Call nurse when the hospital determines that a member is stable for transfer or to obtain authorization for post-stabilization care. The hospital only needs to make one (1) call to the Alliance to request prior authorization for post-stabilization care. If the Alliance does not respond to the request within one-half hour (30 minutes), the post-stabilization care shall be deemed as approved. The first day of post-stabilization will be authorized if the member is eligible with the Alliance on the date of service. The Alliance will follow up with the hospital on the next business day with the authorization number.

To contact the Alliance On-Call Nurse, please call:

Alliance On-Call Nurse

Phone Number: 1.510.326.5271

to provide medically necessary post-stabilization care services within 30 minutes of the request, the services are deemed as authorized. This requirement applies to requests submitted directly to the Alliance and/or its delegates.

The Alliance will make a prompt determination and reasonable payment to, or on behalf of, the member for the service(s) when the financial responsibility is that of the Alliance.

### *FAMILY PLANNING SERVICES AND SENSITIVE SERVICES*

Sensitive services are those services designated by the state Medi-Cal program as available to members without a referral or authorization in order to protect patient confidentiality and promote timely access. Sensitive services include family planning, screening and treatment for sexually transmitted diseases, HIV testing, and abortions. All Alliance Medi-Cal members may go outside of their medical group's network for sensitive services, which does not include prenatal care. Authorization is not required for prenatal care, but members must stay within their medical groups.

Family planning and sensitive services may be billed fee-for-service. All PCPs or OB-GYNs rendering family planning and sensitive services must be documented on the claim form. For Medi-Cal members, family planning and sensitive services may be obtained in or out of network without any prior authorization requirements. For Group Care members, family planning and sensitive services obtained in network do not require prior authorization, but services obtained out of network will require prior authorization.

### *STERILIZATION SERVICES (MEDI-CAL ONLY)*

Written informed consent must be obtained from all members seeking sterilization services. This applies to tubal sterilization, vasectomy, and hysterectomy. For Medi-Cal members only, regulations require that a copy of the signed PM-330 consent form be submitted to payers before payment can be released. Consequently, the Alliance will not

reimburse professional or facility fees associated with tubal sterilizations, vasectomies, or hysterectomies, unless an appropriately completed PM-330 consent form is submitted by the primary surgeon.

### *HIV TESTING AND COUNSELING*

PCPs rendering HIV counseling and testing to assigned members may bill fee-for-service for those procedures.

Providers, other than the assigned PCP, who render HIV counseling and testing services, may bill the Alliance fee-for-service (FFS).

### *MINOR CONSENT SERVICES (MEDI-CAL ONLY)*

Minor Consent Services, described below, may be billed fee-for-service when rendered by a PCP to their assigned Medi-Cal members. Minor Consent Services include:

- Abortions
- Confirmation or rule out pregnancy
- Family planning
- HIV testing
- Sexual assault
- Sexually transmitted diseases

### *VACCINES*

Administration of routine pediatric immunizations is a paid FFS to the PCP. The appropriate administration codes must be submitted on the CMS 1500 form.

For Medi-Cal members, PCPs have access to free vaccines through the Vaccines for Children (VFC) Program. To enroll, call the VFC Program directly. Community and county clinics should call **1.510.267.3230**. Private providers should call **1.510.704.3750**. Vaccines not covered by the VFC Program should be billed directly to the Alliance for reimbursement. If a claim is received and the provider is registered with VFC, the claim will be denied.

### *LABORATORY: CLINICAL, CYTOPATHOLOGY, AND PATHOLOGY*

Quest Diagnostics is the Alliance's contracted partner for most outpatient clinical laboratory services. With the exception of emergency, urgent, PCP-covered labs, sensitive services, or labs specifically identified as reimbursed fee-for-service, laboratory services are carved out to the Alliance's capitated laboratory provider, Quest Diagnostics. Pathology services, identified as CPT-4 procedure code range 88300- 88399, are payable by the Alliance only when performed in conjunction with emergency or urgent care services, or surgical services performed in an inpatient hospital, outpatient hospital, or freestanding surgical facility setting.

Members who are assigned to Alameda Health System (AHS) are capitated for lab

services and will receive laboratory services through one (1) of the following AHS clinics:

| AHS CLINIC | PHONE NUMBER | ADDRESS |
|---|---|---|
| Eastmont Wellness | **1.510.567.5700** | 6955 Foothill Blvd.<br>Oakland, CA 94605 |
| Hayward Wellness | **1.510.266.1700** | 664 Southland Mall Dr.<br>Hayward, CA 94545 |
| Highland Wellness | **1.510.437.5039** | 1411 East 31st St.<br>Oakland, CA 94602 |
| Newark Wellness | **1.510.505.1600** | 6066 Civic Terrace Ave.<br>Newark, CA 94560 |

The Alliance also contracts with Foundation Laboratory.

They provide on-site lab services to members who are seen by these Oakland providers:

| CLINIC | PHONE NUMBER | ADDRESS |
|---|---|---|
| MacArthur Gastroenterology | **1.510.562.7467** | 10520 MacArthur Blvd.<br>Oakland, CA 94605 |
| Roots Community Health Center – Main Clinic | **1.510.777.1177** | 9925 International Blvd.<br>Oakland, CA 94603 |
| Roots Community Health Center – Headquarters Clinic | **1.510.533.1248** | 7272 MacArthur Blvd.<br>Oakland, CA 94605 |

### *OFFICE-BASED INJECTABLES*

Except for injectables administered in an inpatient setting, claims for injectables administered in the office must include the corresponding National Drug Code (NDC) for each drug. Claims that do not include NDCs, invalid NDCs, or NDCs that do not correspond to the procedure code billed will be denied.

## Code Sets (Claims)

### *BILLING CODES*

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete or invalid codes will result in a potential denial of the claim and a subsequent delay in payment.

All providers need to bill with approved Medi-Cal codes. Using non-approved Medi-Cal codes will result in a denial of services.

If you use unlisted or miscellaneous approved Medi-Cal CPT-4 or HCPCS codes, notes and/or a description of services rendered must accompany the claim. The use of unlisted or miscellaneous codes will delay claims payment and should be avoided whenever

possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

Providers will also improve the efficiency of their reimbursement through proper coding and reporting of a member's diagnosis. We require the use and reporting on a claim of valid ICD-10 diagnosis codes, to the appropriate specificity, for all claims. This means that ICD-10 codes must be carried out to the fifth, sixth, or seventh digit when indicated by the coding requirements in the ICD-10 manual. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

### *CODE AUDITING AND EDITING*

The Alliance utilizes code-auditing software for automated claims coding verification, and to ensure that the Alliance is processing claims in compliance with general industry and Medi-Cal standards.

The code-auditing software takes into consideration the conventions set forth in the health care insurance industry, such as regulatory state and federal standards, the National Correct Coding Initiative (NCCI), and Medi-Cal guidelines.

Using a comprehensive set of rules, the code auditing software:

- Accurately applies coding criteria for the clinical areas of medicine, surgery, laboratory, pathology, radiology, and anesthesiology, as outlined by the American Medical Association's (AMA) CPT-4 manual.
- Evaluates the CPT-4 and HCPCS codes submitted by detecting, correcting, and documenting coding inaccuracies, including, but not limited to, unbundling, up-coding, fragmentation, duplicate coding, invalid codes or modifiers, and mutually exclusive procedures.
- Incorporates historical claims auditing functionality that links multiple claims found in a member's claims history to current claims to ensure consistent review across all dates of service.
- The Alliance reviews providers' claims billing patterns and requests medical records for review when needed. Providers are responsible for submitting the requested medical records to the Alliance. Failure to comply with the request may lead to corrective action plans or a possible hold on payments.

## Electronic Visit Verification (EVV) (PS)

Effective on Sunday, January 1, 2023, the Electronic Visit Verification (EVV) requirements established by the California Department of Health Care Services (DHCS) require providers who offer Personal Care Services (PCS) and Home Health Care Services (HHCS) in a member's home to capture and transmit six (6) mandatory data components to DHCS vendor, Sandata. Sandata will supply the visit verifications required by DHCS

to process claims for services. Claims for unverified visits that have not been logged through Sandata may be subject to claim denials.

Below are the six (6) mandatory data components:

The type of service performed
The individual receiving the service
The date of service
The location of the service
The individual providing the service
The time the service begins and ends

Provider types who are required to comply with EVV requirements are:

Day habilitation program providers
Home health providers
Personal care and homemaker providers
Respite providers

Registration link and/or training resources:

Registration: **www.dhcs.ca.gov/provgovpart/Documents/CalEVV-Provider-Self-Registration-QRG.pdf**
Training: **https://sandata.zendesk.com/hc/en-us/articles/8614759432211--CalEVV-New-Provider-Self-Registration-and-Onboarding-Video**
Provider/Claim Types: **www.dhcs.ca.gov/provgovpart/Documents/EVV-Provider-Types-and-Codes-November.pdf**

# Section 9: Provider Dispute Resolutions (PDR) (Claims)

The Alliance offers a fair, fast, and cost-effective dispute resolution mechanism to process and resolve provider disputes. A PDR request may be submitted in writing using the PDR Request Form. Dispute requests must be submitted within **365 calendar days** of the Alliance's most recent action on the disputed claim.

A contracted or non-contracted provider dispute is a provider's written notice challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim or appeal of medical necessity/utilization management decision.

Corrected claims are not accepted through the PDR process. For more information on how to submit a corrected claim, please refer to "Submitting a Claim" in Section 8: Claims.

Each contracted provider dispute must contain, at a minimum, the following information:

- Provider name
- Provider NPI/TIN
- Member name and identification number
- Provider identification number
- Provider contact information
- Claim number
- Supporting documentation
- Reason for the dispute, including a clear explanation of the issue and the provider's position thereon
- If the dispute concerns a claim or a request for reimbursement of an overpayment of a claim – 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;
- If a dispute is about a claim – Must have a processed (paid or denied) claim.
- If the dispute involves a member or group of members – Must include the individual claims numbers, name(s) and identification number(s) of the member(s), and a clear explanation of the disputed item, including the date of service and the provider's position thereon.

Providers can access the Provider Dispute Resolution (PDR) Form on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.

Provider disputes can be submitted by mail or through the Alliance Provider Portal:

Mail:

Alameda Alliance for Health
Attn: Provider Dispute Resolution (PDR) Unit
PO Box 2460
Alameda, CA 94501-0460

Provider Portal:

To submit the form through the Alliance Provider Portal:

- Visit the Alliance website at **www.alamedaalliance.org**.
- Click on the 'Provider Portal' link in the upper right-hand corner and log in.
- Select 'Claims Submission Form.'

Provider disputes that do not include all required information may be returned to the submitter for completion. An amended dispute which includes the missing information may be submitted within **30 working days** of your receipt of a returned provider dispute.

PDRs submitted by mail will be acknowledged within **15 working days** of the receipt date and PDRs submitted electronically (through the Alliance Provider Portal) will be acknowledged within **two (2) working days**; either submission type will be resolved within **45 working days** of the receipt date of the dispute.

A determination from the Alliance is the final decision and will not be reconsidered if resubmitted.

For further instructions on how to submit a PDR request, please call:

Alliance Provider Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4510**.

# Section 10: Telehealth (PS)

This section details telehealth requirements for providers who may provide services via audio or visual telehealth modality as required by state and federal regulations.

## Video and Audio Requirements (PS)

Effective Monday, January 1, 2024, all providers conducting telehealth via audio-only synchronous interactions must also offer those same services via video synchronous interactions.

Providers furnishing services through video or audio-only synchronous interaction must also do one (1) of the following:

4. Offer those same services via in-person, face-to-face contact.
5. Arrange for a referral to and facilitation of in-person care that does not require a member to independently contact a different provider to arrange for that care.
6. Document member consent prior to the initial delivery of covered services via telehealth.
7. Inform the member that telehealth is voluntary, and consent for telehealth may be withdrawn at any time without affecting their ability to access Medi-Cal-covered services in the future.
8. Inform the member about the availability of non-medical transportation (NMT) to in-person visits. Please direct Alliance members to call the Alliance Transportation Services toll-free at **1.866.791.4158**.
9. Inform the member of the potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

## Model Language for Telehealth Patient Consent (PS)

The California Department of Health Care Services (DHCS) has created a document with model language that providers may use as part of their Telehealth Policy Implementation Patient Consent. To view or download the document, please visit the DHCS website at **www.dhcs.ca.gov/provgovpart/Documents/Patient-Consent-Model-Written-Verbal-Language.pdf**. Providers are not required to use the DHCS language but may be used as a resource.

**PLEASE NOTE:** Providers must also document when a member consents to receive covered services via telehealth before the initial delivery of the services. Member consent can be obtained verbally or in writing and then documented by the provider.

## Requirements to Provide Telehealth Services (PS)

Telehealth modality may only be provided and reimbursed if all of the following criteria are satisfied:

1. The treating provider at the distant site believes the covered services being provided are clinically appropriate to be delivered via telehealth based on evidence-based medicine and/or best clinical judgment.
2. The member has provided verbal or written consent.
3. The medical record documentation substantiates that the covered services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service.

   Providers are not required to:

   a. Document a barrier to an in-person visit for covered services provided via telehealth (WIC section 14132.72(d)); or
   b. Document the cost-effectiveness of telehealth reimbursement for covered services provided via a telehealth modality.
4. The covered services provided via telehealth meet all state and federal laws regarding confidentiality of health care information and a member's right to their medical information.

## Reimbursable Telehealth Services (PS)

Certain types of covered services cannot be appropriately delivered via telehealth. These include covered services that would otherwise require the in-person presence of the member for any reason, such as those that are performed in an operating room or while the member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

The provider must assess the appropriateness of the telehealth modality to the member's level of acuity at the time of the service. The provider is not required to be present with the member at the originating site unless determined medically necessary by the provider at the distant site.

All providers, with the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), are allowed to be reimbursed for consultations provided via a telehealth modality. These electronic consultations (e-consults) are permissible using the appropriate CPT-4 code, modifier(s), and medical record documentation defined in the Medi-Cal Provider Manual.

Members cannot initiate e-consults as they are interprofessional interactions, and therefore only permissible between providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a member who is not physically present (face-to-face) at the

fee-for-service (FFS) rate.

The virtual communications reimbursement for FQHCs, RHCs, and THPs was discontinued with the end of the COVID-19 Public Health Emergency on Thursday, May 11, 2023.

## Telehealth Billing - Place of Service Codes and Modifiers (PS)

Telehealth visits may ONLY use CPT codes for an office visit with the appropriate place of service and/or modifier option, regardless of the modality. Providers will continue to be reimbursed at the contracted rate for office visits for these services and are responsible for determining the appropriate place of service code and modifier option to use based on the visit and guidance by DHCS.

| Place of Service Code | Modifier Options | Modifier Description |
|---|---|---|
| **02** - Telehealth Provided Other than in Patient's Home.<br><br>Or<br><br>**10** - Telehealth Provided in Patient's Home. | **95** | For services or benefits provided via **synchronous**, **interactive audio and visual telecommunications systems**. Synchronous means a real-time interaction between a patient and a health care provider located at a distant site. |
| | **GQ** | For services or benefits provided via **asynchronous store and forward telecommunications systems**. Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the health care provider at a distant site. |
| | **93** | For services or benefits provided via **synchronous telephone or other real-time interactive audio-only telecommunications systems**. Synchronous means a real-time interaction between a patient and a health care provider located at a distant site. |

## Telehealth Resources (PS)

10. DHCS website **www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx**
11. DHCS Telehealth Resource Page for Providers **www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx**
12. California Code, Business and Professions Code - BPC § 2290.5
13. Senate Bill 184

# Section 11: Service and Referrals for Adults – Adult Clinical Preventive Services (Health Care Services)

This section details the services for adults receiving benefits as required by state and federal regulations. The Alliance requires PCPs to follow uniform guidelines for adult periodic health examinations in accordance with the US Preventive Services Task Force's "A" and "B" recommendations in the *Guide to Clinical Preventive Services*.

The preventive guidelines can be found at **www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations**. PCPs are required to provide preventive health services to their assigned members.

In addition, all Alliance members over the **age of 21** are required to receive an Initial Health Appointment (IHA) from their PCP, including a complete physical examination and history (see **www.alamedaalliance.org/providers/initial-health-assessment**). At that time, they should also complete a Staying Healthy Assessment (SHA).

For assistance in obtaining a copy of the guide, providers may contact the Alliance Provider Services Department at **1.510.747.4510**.

### *OB/GYN SERVICES*

Alliance members have open access to services provided by in-network OB/GYNs and qualified family practice physicians. Gynecological services provided to a member in the provider's office do not require prior authorization or a referral from their PCP.

### *CANCER SCREENING*

All generally medically accepted cancer screening tests are covered by the Alliance.

Screening and diagnosis of breast cancer is a covered benefit. Mammograms do not require prior authorization. Treatment for breast cancer includes prosthetic devices or reconstructive surgery for a patient incident to mastectomy.

### *DOCUMENTATION*

Documentation of all clinical preventive service encounters must be included in the member's medical record. The medical record will be reviewed for completeness during site reviews conducted by the Alliance.

Providers should report all adult preventive health encounters, whether capitated or fee-for-service, to the Alliance using the CMS 1500.

For more information on adult preventive health services, providers can visit

**www.ahrq.gov/prevention/guidelines/index.html**.

## Immunizations (Health Care Services)

Vaccinations provided to Alliance members over **age 18** do not require prior authorization. Providers may bill the Alliance for administering the vaccine and submitting a CMS 1500 claim form.

## Family Planning Services (Health Care Services)

Medi-Cal members are entitled to timely, convenient, and confidential access to the full range of family planning services. In accordance with federal regulations, Medi-Cal members are allowed freedom of choice in selecting a family planning provider. Therefore, Medi-Cal members may receive such services from a PCP, non-PCP, or an out-of-plan provider, without prior authorization. Members enrolled in other Alliance product lines may see Alliance-contracted providers for family planning services.

### *SCOPE OF SERVICES*

The following family planning services (Medi-Cal members only) are covered for both in-network and out-of-plan providers:

14. Abortions
15. Diagnosis and treatment of STDs if medically indicated
16. Follow-up care for complications associated with contraceptive methods issued by the family planning provider, if provided in an ambulatory setting
17. Health education and counseling necessary to make informed choices and understand contraceptive methods
18. Laboratory tests if medically indicated as part of the decision-making process for the choice of contraceptive methods
19. Limited history and physical examination
20. Pregnancy testing and counseling
21. Provision of contraceptive pills/devices/supplies
22. Screening, testing, and counseling of members at risk for HIV; referral for treatment
23. Tubal ligation
24. Vasectomies

### *TYPES OF PROVIDERS WHO MAY RENDER FAMILY PLANNING SERVICES*

The following types of contracted providers may provide family planning services, as listed previously, within their scope of practice, to Alliance members:

25. Assigned PCPs
26. Family and general practitioners
27. Pediatricians
28. County and community clinics
29. Obstetricians/Gynecologists and Certified Nurse Midwives

30. Family planning clinics
31. STD clinics

Nurse practitioners and physician assistants may provide family planning services through a contracted physician.

### *REFERRALS*

If the member's family planning needs exceed the provider's scope of practice, the member should be referred to an appropriate family planning provider. This referral does not require prior authorization and can be made to a provider within or outside the Alliance provider network (Medi-Cal only).

Providers should assist members in identifying family planning providers. Refer to the Provider Directory or encourage the member to call the Alliance Member Services Department at **1.510.747.4567**. The Alliance Member Services Department can provide referrals for family planning services.

### *INFORMED CONSENT*

Providers must obtain signed informed consent for any invasive procedure done during a family planning visit, such as the insertion of a Norplant or an intrauterine device (IUD) and for sterilization. Although signed consent is not required for all family planning methods, providers must document that members have been informed of the full range of contraceptive choices.

### *OUT-OF-PLAN FAMILY PLANNING SERVICES FOR MEDI-CAL*

#### Covered Out-of-Plan

Medi-Cal members may access family planning services out-of-network but are encouraged to choose a plan provider in order to promote continuity of care. Out-of-network family planning providers must be qualified to provide family planning services based on their licensed scope of practice. Medi-Cal members seeking care from an out-of-network provider should be advised that services are limited to those listed under Scope of Services in this section.

#### Excluded Out-Of-Plan

Out-of-plan providers will not be reimbursed for the following family planning services:

32. Hysterectomy
33. Reversal of voluntary sterilization
34. Routine infertility studies or procedures
35. Transportation, parking, and childcare

## Confidential Human Immunodeficiency Virus (HIV) Testing (Health Care Services)

The Alliance's policy is to ensure members receive information regarding access to

confidential HIV counseling and testing. Alliance Medi-Cal members have the right to confidential HIV counseling and testing within and outside of the Alliance's provider network. Members enrolled in other Alliance product lines may see any Alliance-contracted provider for HIV services.

***IDENTIFICATION***

The following procedures should be followed for the identification of patients who may need confidential HIV counseling and testing:

36. All hemophiliacs
37. Any other STD (i.e., syphilis, gonorrhea, human papillomavirus, chlamydia, pelvic inflammatory disease)
38. Behavior/history Indications
39. Behavior resulting in other blood-to-blood contact, sadomasochism (S&M), tattooing, piercing, etc.
40. Cervical cancer
41. Child of an HIV-infected woman
42. Hepatitis B or C
43. Herpes zoster outbreak in a person under 50 years old
44. Inquire about illicit drug use to identify members who may need HIV counseling and testing
45. Medical indications
46. Men who have had sex with men
47. Perform a thorough history and physical exam, including taking a sexual history
48. Persistent, recurrent, or refractory vaginal candidiasis
49. Persons who have had anal intercourse
50. Received blood/blood transfusion before 1985 or in a country where blood was not tested for HIV
51. Received drugs for sex
52. Received money for sex
53. Refer members for HIV counseling and testing under the following conditions:
    a. Sex with a prostitute/sex partner
    b. Tuberculosis, active disease in a U.S. native, and TB patients unresponsive to treatment
    c. Unexplained, persistent weight loss, diarrhea, or fever
    d. Use of intravenous drugs or other substances

All pregnant women should be offered and encouraged to have HIV counseling and testing whether or not they seem to be at risk for HIV infection, in accordance with California law.

For a complete list of test sites, please call the County Office of Acquired Immune Deficiency Syndrome (AIDS) at **1.510.873.6500**.

***REFERRAL***

Providers may refer a patient requesting confidential HIV testing to a confidential test site, family planning, or a sexually transmitted disease provider within the Alliance provider network for all product lines. Referrals to in-plan sites are encouraged; however, Medi-Cal members do have the option of seeking HIV testing through non-contracted providers.

Providers should advise any member who chooses to go to an out-of-plan confidential test site to sign a release of information form to allow their name to be submitted on the claim. If the claim is submitted without a name to determine eligibility for services, the Alliance will not reimburse the provider.

### *ALLIANCE-CONTRACTED HIV TEST SITES*

The following test sites are within the Alliance's network:

| TEST SITE | PHONE NUMBER | ADDRESS |
|---|---|---|
| Alameda County Medical Center - Highland Hospital | **1.510.437.4800** | 1411 E. 31st St. Oakland, CA 94602 |
| Asian Health Services | **1.510.986.6800** | 818 Webster St. Oakland, CA 94607 |
| Axis Community Health Center | **1.925.462.1755** | 5925 W. Las Positas Blvd. #100 Pleasanton, CA 94566 |
| Berkeley Public Health Clinic | **1.510.981.5350** | 830 University Ave. Berkeley, CA 94710 |
| East Oakland Health Center | **1.510.430.9401** | 7450 International Blvd. Oakland, CA 94621 |
| Eastmont Wellness Center | **1.510.577.5668** | 6955 Foothill Blvd. Oakland, CA 94605 |
| La Clínica de la Raza - Clínica Alta Vista | **1.510.535.4000** | 3451 E. 12th St. Oakland, CA 94601 |
| Native American Health Center | **1.510.535.4460** | 3124 International Blvd. Oakland, CA 94601 |
| Planned Parenthood, Hayward | **1.510.733.1819** | 1866 B St. Hayward, CA 94541 |
| San Antonio Health Center | **1.510.238.5400** | 1030 International Blvd. Oakland, CA 94606 |
| Bay Area Community Health | **1.510.770.8133** | 39500 Liberty St. Fremont, CA 94538 |
| West Oakland Health Center | **1.510.835.9610** | 700 Adeline St. Oakland, CA 94607 |

Please remember to report all AIDS cases to the County Communicable Disease Division at **1.510.267.3240**.

## **Abortion Services** (Health Care Services)

The following guidelines apply to Alliance abortion services:

54. In-network abortion services are available to all members without a referral or prior authorization.
55. Alliance Medi-Cal members have the right to abortion services within and outside of the Alliance provider network without a referral or prior authorization.
56. The Alliance will not reimburse for abortions provided by out-of-plan providers for Group Care members without prior authorization.
57. Every effort shall be made to assist members seeking abortion services. This includes providing timely and appropriate counseling, education, information, and referral.
58. Providers shall assist members in identifying abortion service providers. Providers should refer to the Provider Directory or encourage the member to call the Alliance Member Services Department at **1.510.747.4567**.

## Sterilization Services (Health Care Services)

Written informed consent must be obtained from all members seeking sterilization procedures in accordance with state law. This applies to all members regardless of the product line in which they are enrolled and includes services for tubal ligations, sterilization, vasectomies, and hysterectomies.

A copy of the signed sterilization consent form must be maintained in the member's medical records. For Medi-Cal members, a copy of the consent must also be submitted to the Alliance in order to be reimbursed (see below). Consent submission to the Alliance only applies to Medi-Cal members. Providers do not need to submit a copy of the consent to the Alliance for members in other product lines.

Prior authorization is not required for tubal ligations or vasectomies. Prior authorization is required for hysterectomies.

### *REQUIREMENTS REGARDING CONSENT*

The legal requirements listed below apply to the provision of sterilization services. Sterilization is covered only if all applicable requirements are met at the time the procedure is performed. If the member obtains retroactive coverage, previously provided sterilization services for tubal ligations and vasectomies are not covered unless all applicable requirements and California State Law, including the timely signing of an approved sterilization consent form, have been met.

### *MEDI-CAL MANAGED CARE REQUIREMENTS*

Alliance members enrolled in Medi-Cal Managed Care must meet the requirements of the law specific to Medi-Cal-funded members. This means that a member cannot waive the **30-day** waiting period between the date of written consent and the actual performance of the procedure unless an emergency is documented in accordance with Title 22 CCR 51305.1.

When submitting claims for Medi-Cal members, a copy of an appropriately completed PM-330 must be submitted with a claim for vasectomies and tubal ligations. Failure to submit the PM-330 will result in the denial of payment to all providers involved in the delivery of the service until a properly completed PM-330 is submitted. If the PM-330 has not been properly completed in accordance with Medi-Cal guidelines, payment may be denied.

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

Providers must provide alcohol and drug screening, assessment, brief interventions and referral to treatment (SABIRT) to members **11 years of age** and older, including pregnant women. Unhealthy alcohol and drug use screening must be conducted using validated screening tools. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use, alcohol use disorder (AUD), or substance use disorder (SUD) is present. Assessment can be done without first using screening tools.

Brief misuse counseling should be offered for unhealthy alcohol use. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered for patients with probable AUD or SUD.

Brief interventions must include the following:

- Discussing negative consequences and the overall severity of the problem
- Supporting the patient in making behavioral changes
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated

Member medical records must include the following:

- The service provided
- The name of the screening instrument and score
- The name of the assessment instrument and score
- If and where a referral to an AUD or SUD program was made

### *VALIDATED SCREENING AND ASSESSMENT TOOLS*

Below are resources for validated screening and assessment tools.

Screening tools:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID): **www.pedagogyeducation.com/Main-Campus/Resource-Library/Correctional-Nursing/CAGE-AID-Substance-Abuse-Screening-Tool.aspx**
- Tobacco Alcohol, Prescription medication and other Substances (TAPS): **www.drugabuse.gov/taps**

59. National Institute on Drug Abuse (NIDA) Quick Screen for adults – The single

NIDA Quick Screen alcohol-related question can be used for alcohol use screening: **archives.drugabuse.gov/nmassist**
Drug Abuse Screening Test (DAST-10) (fee required): To use this tool, please email Dr. Harvey Skinner at **hskinner@yorku.ca**

- Alcohol Use Disorders Identification Test (AUDIT-C): **www.hepatitis.va.gov/alcohol/treatment/audit-c.asp**
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents: **www.ntiupstream.com/4psabout**
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents: **www.crafft.org**
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population: **hign.org/sites/default/files/2020-06/Try_This_General_Assessment_17.pdf**

Assessment tools:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST): **https://archives.drugabuse.gov/nmassist/**
- Drug Abuse Screening Test (DAST-20) (fee required): To use this tool, please contact Dr. Harvey Skinner at **hskinner@yorku.ca**
- Alcohol Use Disorders Identification Test (AUDIT): **auditscreen.org**

### *BILLING FOR SERVICES*

**SABIRT Billing Codes and Frequency Limits Table**

| BILLING CODE | DESCRIPTION | WHEN TO USE | FREQUENCY LIMIT |
|---|---|---|---|
| G0442 | Annual alcohol misuse screening, **15 minutes** | Alcohol use screening | One (1) per year, per provider |
| H0049 | Alcohol and/or drug screening | Drug use screening | One (1) per year, per provider |
| H0050+ | Alcohol and/or drug services, brief intervention, per **15 minutes** | Alcohol misuse counseling or counseling regarding the need for further evaluation/treatment | One (1) per year, per provider |

### *REFERRALS FOR TREATMENT*

For Alliance Medi-Cal members:

Alameda County Behavioral Health Substance Use Treatment and Referral Helpline
Toll-Free: **1.844.682.7215**
**www.acbhcs.org/substance-use-treatment**

For Alliance Group Care members:

Alameda Alliance Member Services
Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**

## Tobacco Cessation (Health Ed)

Alliance providers are responsible for tobacco use tracking, counseling, and referrals. Providers should ask all patients about tobacco use at every visit and have a tobacco user identification system to track use.

Below are various ways to track:

60. Record in your electronic health record (EHR)
61. Use ICD-9 codes for pregnancy-related tobacco use
62. Use ICD-10 codes for nicotine dependence
63. Use CPT codes for tobacco cessation counseling

### *TOBACCO CESSATION COUNSELING*

The Alliance covers the following types of tobacco cessation counseling and referrals:

64. **Individual Counseling:** Providers can bill for tobacco cessation counseling.
65. **Group Counseling:** Refer patients to Alliance Health Programs at **1.510.747.4577** for group classes.
66. **Telephone Counseling:** Refer patients to Kick It California. Patients can call toll-free at **1.800.300.8086** or visit **kickitca.org.** Kick It can help people quit smoking, vaping, and smokeless tobacco.

For additional training and resources on tobacco cessation counseling, please visit **www.alamedaalliance.org/providers/provider-resources/tobacco-provider-guide**.

# Section 12: Services and Referrals for Newborns, Children, and Adolescents (Health Care Services)

This section describes the health care services that children in the Alliance are entitled to receive. Like adults, children are entitled to some services outside of the scope of a provider's practice. In such cases, providers should make assessments and, as appropriate, referrals for the conditions covered in this section.

## Newborn Services (Health Care Services)

### *ELIGIBILITY*

Babies born to mothers who are Alliance members are covered by the Alliance during the "newborn period."

The newborn period is not the same for all lines of business, and is calculated as follows:

- Medi-Cal Newborns – Covered for the calendar month of birth and the month after.
- If the mother does not apply for the baby to receive their own insurance benefits, the baby will not be eligible for services, including Alliance services, after the newborn period. When this occurs, providers will not receive reimbursement or capitation for the baby from the Alliance.
- The Alliance sends reminders regarding newborn eligibility to the mother and can assist by providing enrollment information. However, providers are encouraged to also remind the parent/guardian to obtain separate benefits for the newborn and to choose a health plan and a PCP for continuity of care.
- Group Care Newborns – Covered from the date of birth through the first **30 days** of life only.
- Dependents are not eligible to enroll in the Alliance Group Care Program.

### *BILLING*

Pediatric care will be paid on a fee-for-service basis for attending the delivery, routine newborn care, and sick newborn care during the newborn period. It is important to verify the mother's eligibility before providing service to the newborn.

### *PHENYLKETONURIA (PKU) TESTING & TREATMENT*

Testing and treatment of phenylketonuria (PKU), including formulas and special food products, are a covered benefit based upon the following guidelines:

- Part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of

metabolic disease and who participates in or is authorized by the Alliance; and

- Provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

## Clinical Preventive Services for Children – Periodic Health Assessments (Health Care Services)

This section outlines the PCP's responsibilities for preventive care services for children.

Periodic health assessments must be provided by PCPs for all members under **21 years of age**, according to the periodicity schedule and content of the most current Bright Futures/American Academy of Pediatrics (AAP) recommendations for preventive pediatric health care.

If the provider sees a child for urgent care and that child is not yet assigned to a PCP, the provider will be reimbursed at the base Medi-Cal fee-for-service rate for care, including preventive care provided at that visit.

### *BLOOD LEAD SCREENING*

The PCP must provide oral or written anticipatory guidance to a parent or guardian of the child that, at minimum, includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from **six (6) months** until **72 months** of age. This guidance must be performed at each periodic health assessment, starting at **six (6) months** of age and continuing until **72 months** of age.

Blood lead screening is required for all children at **12 months** and **24 months** of age. If the provider performs a periodic health assessment and becomes aware that a child between **12 months** and **72 months** has no documented blood lead testing at either the **12-month** or **24-month** interval, the provider performs blood lead testing, or blood lead testing is completed anytime it is requested by the parent or guardian. The blood lead level test is not required if the parent or guardian refuses to consent or the PCP determines it poses a risk to the child's health that is greater than the risk of lead poisoning. Any reason for not screening must be documented in the child's medical record. In cases where consent has been withheld, the medical record must include a signed statement of voluntary refusal or documentation of the reason for not obtaining one. Blood lead screening encounters should be identified using the appropriate CPT codes.

PCPs must follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidance when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. CLPPB guidelines can be found at **www.cdph.ca.gov/Programs/ccdphp/deodc/clppb/pages/prov.aspx**.

### *WRITTEN RESULTS*

For Medi-Cal members, PCPs must provide written results to the member (or the member's parent or guardian, as appropriate) of the initial or periodic health assessments.

### *FOLLOW-UP ON MISSED OR CANCELED APPOINTMENTS*

PCPs must follow up on missed or canceled appointments for preventive care. At least three (3) attempts to contact the member should be made and documented in the medical record.

### *DOCUMENTATION OF PREVENTIVE SERVICES*

The DHCS Facility Site Review (FSR) requirements include outreach from the provider when members have missed appointments.

The process established on-site provides timely access to appointments for routine care, urgent care, prenatal care, pediatric periodic health assessments/immunizations, adult Initial Health Appointments (IHA), specialty care and appointments, and follow-up of missed or canceled appointments. Systems, practices, and procedures used for making services readily available to patients will vary from site to site.

Missed and/or canceled appointments and contact attempts must be documented in the patient's medical record.

For all Alliance members, preventive services including visits and immunizations must be billed to the Alliance, using the CMS 1500 billing form.

## Cognitive Health Assessments (Health Care Services)

Cognitive health assessments are covered directly by the Alliance for members who are **65 years of age** and older and who do not have Medicare coverage. Providers must obtain Dementia Care Aware training approved by the Department of Health Care Services (DHCS) on conducting the assessment before administering and billing for the assessment. Cognitive health assessment training is available at **www.dementiacareaware.org**.

### *BILLING*

To appropriately bill and receive reimbursement for conducting an annual cognitive health assessment, providers must do all of the following:

- Complete the DHCS Dementia Care Aware cognitive health assessment training.
- Be a contracted and credentialed provider with the Alliance.
- Bill in accordance with Medi-Cal billing requirements Current Procedural Terminology (CPT) code 1494F and quantity limits.
- Administer the annual cognitive health assessment as a component of an E&M visit including, but not limited to an office visit, consultation, or preventive medicine service.

- Document all of the following in the member's medical records and have such records available upon request:
- The screening tool or tools that were used (at least one (1) cognitive assessment tool listed below is required);
- Verification that screening results were reviewed by the Provider;
- The results of the screening;
- The interpretation of results; and
- Details discussed with the member and/or authorized representative and any appropriate actions taken regarding screening results.

At least one (1) cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- Cognitive Assessment Tools or patient assessment tools
- General Practitioner assessment of Cognition (GPCOG)
- Mini-Cog
- Informant tools (family members and close friends)
- Eight-item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly

## Immunizations (Health Care Services)

### *STANDARDS*

. The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations, regardless of member's age, sex, or medical condition, including pregnancy. Immunization information is available from the Centers for Disease Control (CDC) at **www.cdc.gov/vaccines**

### *PROMOTION*

Pediatric immunizations must comply with the most recent standards of the Pediatric Immunization Practices (U.S. Public Health Service and AAP) and the Recommended Childhood Immunization Schedule (ACIP and AAP). These schedules are accessible via the Alliance website at **www.alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines**. Additional information is available on the CDC website at **www.cdc.gov/vaccines/index.html.**

Adult vaccines recommended by the U.S. Food and Drug Administration (FDA) and ACIP are covered by the Alliance, without cost sharing.

Additional information is available on the CDC website:

https://www.cdc.gov/vaccines/?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/To increase immunization rates, all PCPs are encouraged to:

- Use the California Immunization Registry (CAIR), ideally with a bi-directional interface between CAIR and the practice's electronic health record (EHR). Resources for practices can be found at **http://cairweb.org/how-cair-helps-your-practice**.
- Establish or update electronic medical record (EMR)/EHR templates to accurately reflect coding for visit reason and diagnosis.
- Utilize "flag" alerts in the EMR/EHR system for staff to identify and communicate with members/parents/guardians that immunization is due at every member encounter.
- Appoint a vaccine coordinator.
- Use huddle time to brief/communicate member/patient needed service(s).
- Use any and all visits, as appropriate, to provide immunizations.
- Create immunization-only services or walk-in immunization clinics.
- Communicate with families when vaccinations are due (reminders) or late (recall) via portals, texts, and/or calls.
- Train staff on immunization schedule and how to address vaccine hesitancy.

### *VACCINES FOR CHILDREN (VFC) PROGRAM (MEDI-CAL ONLY)*

PCPs have access to free vaccines for Medi-Cal members **0-18 years of age** through the Vaccines for Children (VFC) Program. The administration fee for routine pediatric immunizations is paid on a fee-for-service basis for Alliance directly contracted providers. When the VFC Program does not provide the vaccine for the Medi-Cal program or other Alliance product lines, the PCP may bill the Alliance without prior authorization for the vaccine by submitting an invoice with the CMS 1500 claim form. Providers who would like to inquire about how to bill the Alliance directly should contact Alliance Provider Services at **1.510.747.4510** for more information.

To contact the VFC Program:

- Community and county clinics can call **1.510.267.3230**
- Private providers can visit the California Vaccine Programs – California Vaccines for Children (VFC) 110 website at **eziz.org** for more information.

### *IMMUNIZATION EDUCATION*

Federal law requires that Vaccine Information Sheets be handed out (before each dose) whenever certain vaccinations are given. These sheets are produced by the CDC, which explains to vaccine recipients, their parents, or their legal representatives both the benefits and the risks of a vaccine.

All handouts can be downloaded from the Immunization Action Coalition website at **www.immunize.org**.

### *VACCINE STORAGE*

Providers are required to have a freezer and a refrigerator for vaccine storage.

### *DOCUMENTATION*

Medical record documentation of member immunization status is required. Immunization status and immunizations given should also be documented. Documentation of each member's need for ACIP recommended immunizations is required as part of all regular health visits, including but not limited to illness, care management, or follow up appointments, initial health appointment (IHAs), pharmacy services, prenatal and postpartum care, pre-travel visits, sports, school, or work physicals, visits to a local health department, and well patient check ups

### *REPORTING*

. All health care providers who administer vaccines must submit patient vaccination records to local health departments, Division of Communicable Diseases Control and Prevention, using the Confidential Morbidity Report Card and appropriate immunization registries within the specified timelines in accordance with Health and Safety Code (H&S) 120440 and 16 CCR 174.4 (e) as applicable. All immunization records must be reported within 14 calendar days, in accordance with state and federal law.

## Early Periodic Screening Diagnosis and Treatment (EPSDT) (Medi-Cal Only) (QI)

Medi-Cal for Kids and Teens (also known as EPSDT) services are a benefit for Medi-Cal members under **21 years of age** to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early, such as a defect, physical or mental illness, or other conditions. EPSDT services must be identified and referred in a timely manner.

### *METHODS OF SCREENING*

- Well-child visits.
- Regular check-ups to look for any problems with the member's medical, dental, vision, hearing, mental health, and any substance use disorders. The Alliance covers screening services any time there is a need for them, even if it is not during a regular check-up.
- Preventive care can be shots. The PCP must make sure that all enrolled children get the needed shots at the time of any health care visit.

When a physical or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem.

These services covered by the Alliance include:

- Behavioral health treatment for autism spectrum disorders and other developmental disabilities
- Case management, targeted case management, and health education
- Doctor, nurse practitioner, and hospital care
- Home health services, which could be medical equipment, supplies, and appliances
- Physical, speech/language, and occupational therapies
- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance
- Shots
- Treatment for vision and hearing, which could be eyeglasses and hearing aids

### *OTHER EPSDT SERVICES*

If the care is medically necessary and the Alliance is not responsible for paying for the care, then the PCP should refer the member to California Children's Services (CCS) to get the care they need.

These services include:

- Private duty nursing services
- Treatment and rehabilitative services for mental health and substance use disorders
- Treatment for dental issues, which could be orthodontics

### *REFERRALS FOR EPSDT SERVICES*

PCPs have a responsibility for identifying the need for EPSDT services through routine primary care of Alliance members under **21 years of age**. Appropriate diagnostic and treatment services must be initiated 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.

Members/families must request EPSDT services through their PCP. An Alliance Prior Authorization (PA) Request Form must be submitted for EPSDT services. The Alliance will not pay for EPSDT services that have not received prior authorization. If EPSDT services are rendered under emergency conditions, standard procedures for emergency care must be followed.

If an out-of-plan provider (such as a mental health specialist, school nurse, or family planning provider) who is providing services to an Alliance member determines that EPSDT services are needed, that provider must contact the Alliance Health Care Services Department. The Alliance Health Care Services Department will notify and consult with the member's PCP.

### *PROVIDER TRAINING REQUIREMENTS FOR EPSDT SERVICES*

Alliance contracted pediatric and family medicine providers must complete the new Medi-Cal for Kids & Teens Provider Training developed by the California Department of Healthcare Services (DHCS). The self-paced training outlines the requirements for the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit for Medi-Cal members under age 21.

Starting Monday, January 1, 2024, providers must complete the training no less than once every two (2) years. This also includes any contracted primary care providers (PCPs) such as medical doctors (MD), Doctor of Osteopathic Medicine (DO), physician assistants (PA), and nurse practitioners (NP) levels that see members under the age of 21 years of age.

Alliance contracted providers can access the training by visiting the Alliance website at **www.alamedaalliance.org/providers/provider-resources/training-and-technical-assistance-opportunities**.

### *CASE MANAGEMENT & COORDINATION OF CARE*

The PCP must maintain ongoing communication with the EPSDT services provider in order to ensure coordination of care. This communication shall be documented in the medical record. The PCP is still responsible for providing primary care services, diagnostic and treatment services, and appropriate referrals for specialty care.

## Women, Infants & Children (WIC) (Health Ed)

The WIC Program provides supplemental food vouchers and nutritional counseling to pregnant and breastfeeding women and infants and children **five (5) years of age**. Eligibility is based on income.

Alliance providers of pediatric care should ensure the appropriate and timely referral of infants and children to the WIC Program. Alliance prenatal providers may refer pregnant women to WIC by having them call toll-free at **1.800.852.5770** or by visiting **myfamily.wic.ca.gov.**

## Early Intervention Services (Health Care Services)

The Early Start Program is designed to provide comprehensive, coordinated, and family-focused early intervention services to children from **birth to age three (3)**, who have, or are at risk for, developmental disabilities. Providers are responsible for the appropriate and timely referral of children from **birth to age three (3)** to the Early Start Program, and for participating in the coordination of care provided to children enrolled in the program.

### *IDENTIFICATION*

PCPs are responsible, through the assessment and examination process, for identifying Alliance members with the Early Start Program's eligible conditions. Identification of the following conditions in a child **0-36 months** of age requires a referral within **two (2) working days** to the program.

### *DEVELOPMENTAL DELAYS*

A developmental delay may exist where there is a significant difference between the infant or toddler's current level of functioning and the expected level of development for his or her chronological age in one (1) or more of the following developmental areas:

- Adaptive
- Communication
- Physical and motor including vision, hearing, and health status
- Social or emotional

### *REFERRALS*

Providers should refer directly to the appropriate agency for the Early Start Program as outlined below. Attempts should be made to obtain consent from the parents prior to making the referral. Providers must also release any requested information directly to the referral agency. Members may also self-refer to the Early Start Program.

For developmental delays or disabilities or high-risk infants, providers should refer to:

- Regional Center of the East Bay at **1.510.618.6100**
- Family Resource Network at **1.510.547.7322**
- Help Me Grow toll-free at **1.888.510.1211**

### *CASE MANAGEMENT AND ONGOING CARE*

PCPs maintain responsibility for basic case management of a child enrolled in the Early Start Program and for referrals for specialty care as indicated. PCPs should participate, as appropriate, in the development and monitoring of the Individual Family Service Plan managed by the referral agency. PCPs must also make medical reports available, as requested, to the early intervention team in order to support their completion of the Individual Family Service Plan within the mandated **45-day** time limit after the referral is made.

# Section 13: Perinatal Services (Health Care Services)

The Alliance defines perinatal services as care delivered to a pregnant woman to diagnose and manage the pregnancy and related conditions, the delivery, and the postpartum follow-up. The standards for the treatment of pregnant women in this section will help providers meet the goals we all share – healthy mothers and children. All providers who offer obstetrical (OB) services to members are required to follow the most current editions of the Standards for Obstetric Services and guidelines from the American College of Obstetricians and Gynecologists (ACOG).

The Alliance recognizes that the Medi-Cal enrollment process may present a challenge to providers in the provision of quality prenatal care. Many women enter the plan well into their pregnancies. Regardless of when a pregnant woman enters the plan, it is imperative that providers see pregnant women as soon as possible.

### *PRENATAL PROVIDER ROLE*

Prenatal providers should follow the same authorization protocols as PCPs.

The prenatal provider, during the course of the member's pregnancy, is considered the gatekeeper or manager of the member's care. As such, prenatal providers may refer members to specialty services, all such referrals and authorizations must be given prior to the provision of care. Retrospective authorization of services is not permitted.

## Perinatal Services (Health Care Services)

### *PREGNANCY TESTING*

Pregnancy testing is available to members through their PCP or from any obstetrician/ gynecologist (OB/GYN), or family planning provider. No prior authorization is needed. A Medi-Cal member may receive a pregnancy test within or outside of the Alliance network. Alliance members enrolled in Alliance programs other than Medi-Cal must receive pregnancy test services in-network.

### *PRENATAL CARE APPOINTMENTS*

Entry into prenatal care does not require a referral or prior authorization. Prenatal appointments should be scheduled within **two (2) weeks** of the member's request.

Members may go to any OB provider in the Alliance network unless they are assigned to CHCN. CHCN members must receive OB care from a CHCN provider or a provider contracted with CHCN.

### *HIGH-RISK PRENATAL CARE*

If a member's medical history or current condition indicates she may have a high-risk

pregnancy, the member may be referred to the following types of Alliance practitioners:

1. A Sweet Success affiliate for pregnancy and diabetes
2. Genetic counselors
- Pediatricians and neonatologists for intensive newborn care and follow-up
3. Perinatologists and obstetricians certified for high-risk care
4. Tertiary ultrasonographers

To find the above providers, please refer to the Alliance Provider Directory.

### *DELIVERY*

Members must deliver at an in-network hospital with which their prenatal provider is affiliated.

### *NOTIFICATION OF ADMISSION*

The hospital is responsible for contacting the Alliance Health Care Services Department when the member is admitted for delivery within **one (1) working day** of admission.

### *POSTPARTUM CARE*

The routine postpartum visit should generally be provided **21-56 days** after delivery, although this interval may be modified if warranted by the needs of the patient. The postpartum review should include interval history and physical examination, laboratory data as indicated, family planning counseling, nutritional health education, and psychosocial reassessments.

The Alliance reimburses fee-for-service (FFS) for the postpartum visit using CPT code 59430, as long as the date of service is on or between **21-56 days** from the date of birth.

### *NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT*

**Notice During Prenatal Care**

During the course of prenatal care, prenatal providers must give Alliance members written notice of their benefits coverage under the Newborns' and Mothers' Health Protection Act of 1997 (NMHPA). NMHPA may not restrict benefits for a hospital stay in connection with childbirth to less than **48 hours** following a vaginal delivery or 96 hours following a delivery by cesarean section beginning at the time of the hospital admission.

If the attending provider, in consultation with the mother, determines that either the mother or the newborn child can be discharged before the **48-hour** (or **96-hour**) period, the Alliance does not have to continue covering the stay for the one ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to the mother or the newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. A health plan, hospital, insurance company, or HMO would not be an attending provider.

**Maternity Lengths of Stay**

A health plan cannot require discharge from a maternity stay sooner than **48 hours** (vaginal delivery) or **96 hours** (cesarean section) unless certain criteria are met. The Alliance does not limit maternity lengths of stay. A decision to discharge must be made by the treating physician in consultation with the mother. The prenatal provider must then advise the mother that she may receive a post-discharge follow-up visit within **48 hours** of discharge.

## *PERINATAL ASSESSMENT*

Many providers may be affiliated with the Comprehensive Perinatal Services Program (CPSP). The forms and protocols connected with this program satisfy Medi-Cal Managed Care requirements for perinatal assessment and intervention.

If a provider is not affiliated with CPSP, it is necessary to do comparable perinatal assessments. This assessment should be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record. The Alliance provides prenatal assessment forms in the Alliance threshold languages. The Alliance recommends all providers use the Alameda CPSP postpartum assessment.

Please see the referenced sections of this manual for details on how to refer to these programs or services:

1. Dental Services
2. Family Planning
3. Genetic Screening and Counseling
4. Perinatal Health Education Classes and Handouts
5. STD Screening and Treatment
6. WIC

## *PRENATAL CARE AND CONSULTATIONS BY PERINATOLOGISTS*

Perinatologists may provide three (3) types of services to Alliance members:

1. Consultations
2. Perinatology OB care
3. Routine OB care

The authorization and claims process that perinatology practices must follow for each of these types of services is detailed below. Payment will be denied for any service that requires but has not received, prior authorization from either the prenatal provider or the Alliance Health Care Services Department.

## *ROUTINE OB CARE (NOT PERINATOLOGY)*

Routine OB care provided to Alliance members by a Perinatology practice, which is not Perinatology care, must be billed according to the standard OB billing procedures.

Routine OB care does not require an authorization number and will be paid at the applicable global rate.

### *ONGOING PERINATOLOGY CARE*

If an Alliance member's total OB care must be managed by the perinatologist because of a high-risk medical condition, the following procedures apply:

1. The perinatologist must submit an Alliance Prior Authorization (PA) Request Form to the Alliance in order to obtain authorization for that pregnancy to be billed fee-for-service (FFS) by the perinatology practice. The medical condition necessitating perinatology management must be documented.
2. The Alliance Health Care Services Division will issue an authorization number for all services related to that high-risk pregnancy.
3. The CMS 1500 is submitted for all services rendered and payment is made on an FFS basis. Each CMS 1500 must have the original authorization number issued for that pregnancy documented in Box #23.
4. The perinatologist is responsible for the administration of the required perinatal assessments. Forms for this assessment have been developed and translated by the Alliance. Per the Medi-Cal Managed Care direction, this assessment should be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified should be followed up on by appropriate interventions, which must be documented in the medical record. The assessment must also be kept in the medical record.

## Reimbursement and Documentation of OB Services (Claims)

- Use an HCFA 1500 (CMS 1500) form to bill for all prenatal, delivery, and postpartum services.
- Submit claims within the following time frame:
  - Initial prenatal visit - within **90 days** of the first prenatal visit.
  - The balance of the prenatal care and the delivery – within **90 days** of the delivery postpartum office visit (must be provided between **21-56 days** after the delivery date) – within **90 days** of the date of service.
- When submitting a claim for the initial prenatal visit:
  - Use the appropriate ICD-10 codes to document a high-risk pregnancy. The diagnosis code submitted on the initial prenatal visit claim will determine whether that visit is paid at the normal or at-risk rate.
- When submitting a final claim for antepartum and/or delivery care, services will be paid according to the following:
  - Global payment when antepartum care and delivery services are provided.
  - FFS when antepartum care only is provided; determined by the total number of visits.
  - If only two (2) or three (3) antepartum visits are provided, bill individually for each of these visits. If a total of four (4)-six (6), or seven (7) or more visits are provided, bill the appropriate code for that number of visits (in addition to the initial visit).

    - FFS when delivery only.
- Postpartum office visits will only be reimbursed when the postpartum visit is between **21-56 days** after delivery.

### *SERVICES INCLUDED IN GLOBAL PAYMENTS FOR OB CARE*

The following services are included in the risk-adjusted global OB payments:

- Prenatal visits
- Prenatal laboratory tests sent to Quest
- Hospital visits for delivery stays less than **72 hours**
- Health education, nutrition, and psychosocial counseling provided by office staff, unless authorized by Alliance
- Hospital visits, except antepartum greater than **72 hours**
- Delivery

### *SERVICES NOT INCLUDED IN GLOBAL PAYMENTS FOR OB CARE*

The following services are not included in the global OB payments and may be billed fee-for-service:

1. Abortions
2. Amniocentesis
3. Chorionic villus sample
4. Family planning visit
5. Immunizations
6. Lab tests included in the PCP capitation scope of service
7. Non-stress tests
8. Postpartum care (only when provided **21-56 days** from delivery)
9. Pregnancy test
10. Prenatal genetic testing
11. Sonograms
12. Treatment of a sexually transmitted disease
13. Tubal ligations

# Section 14: Community Supports (CS) (LTSS)

Community Supports (CS) services may be available for all Alliance members that qualify. CS are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members to receive. These services are short-term services that may help members live more independently, but do not replace benefits they already get under Medi-Cal or other entities. Community Supports follows all Utilization Management regulations. For authorization turnaround timeframes, please see the table below.

| REQUEST TYPE | TURN AROUND TIME |
|---|---|
| Urgent | **72 hours** |
| Routine | **5 business days** |
| Retrospective/Post Service | **30 calendar days** |

### *CS SERVICES OFFERED BY THE ALLIANCE*

The Alliance is currently offering the following CS services:

- Asthma Remediation
- Caregiver Respite Services
- Community Transition Services/Nursing Facility Transition to Home
- Environmental Accessibility Adaptations (Home Modifications)
- Homeless-related CS (includes Housing Transition Navigation, Housing Deposits, and Housing Tenancy & Sustaining Services)
- Medically Tailored/Supportive Meals
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Personal Care and Homemaker Services
  Recuperative Care (Medical Respite)

There is no cost to the member for CS services.

Members can be referred to Community Supports by their provider or by calling:
Alliance Case Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4512**
Toll-Free: **1.877.251.9612**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

# Section 15: Out-of-Plan Services (Health Care Services)

Alliance Medi-Cal members are entitled to many services that are not provided through the Alliance. Providers must ensure that members have access to these out-of-plan services and may also be referred to as carved-out services or other Medi-Cal program and services. The Alliance requires providers to assess each member for the various types of services included in this section and refer members appropriately.

## California Children Services (CCS) (Health Care Services)

California Children Services (CCS) Alliance Medi-Cal members **0-21 years of age** can receive care through CCS for specific eligible conditions as outlined in this section. CCS financial eligibility is automatic with Medi-Cal coverage. Providers treating a member with a CCS-eligible condition and/or an open CCS case should obtain authorization for services for that condition directly from CCS. The Alliance will also work directly with CCS to coordinate the payment of care; this involves referring eligible cases, obtaining authorization from CCS, and forwarding claims for payment if there is an open authorization. If the condition is not CCS-eligible or if CCS eligibility is uncertain, providers should follow the authorization procedures for the Medi-Cal Program members.

**PLEASE NOTE:** The provider must be an authorized (also known as paneled) CCS provider to provide care and receive compensation for the treatment of a CCS patient for the eligible condition.

To obtain more information about the paneling process and to submit an application, please visit **https://cmsprovider.cahwnet.gov/PANEL/index.jsp**.

### *CONDITIONS ELIGIBLE FOR CCS*

Please refer to the DHCS website for conditions eligible for CCS listing at **www.dhcs.ca.gov/services/ccs/Pages/default.aspx**.

### *ESTABLISHING A CCS CASE*

Any provider, parent, social worker, or teacher may contact CCS to establish a case. Contacting CCS is not an authorization of service but does establish the earliest date for which eligibility may apply and begins the process of opening the case. A CCS referral, an Alliance authorization, or a PCP referral must be in place for any services to be covered.

The Alliance will pay for all medically necessary services during the interim referral period and if CCS denies the case. PCPs who identify a condition that may require CCS services should complete and submit an Alliance Prior Authorization (PA) Request Form for other services, such as DME or inpatient and outpatient services. Submission of the form

ensures that providers will be paid by the Alliance for medically necessary services, if CCS determines the condition is not medically eligible for CCS.

Indicate on the Alliance PA Request Form that a referral to CCS is requested. The Alliance will refer any case to CCS whose diagnosis might meet CCS eligibility criteria. Members can begin care with the specialist immediately.

Providers do not have to wait for CCS to determine eligibility because the services have been authorized by the Alliance or the PCP and will be paid by the Alliance in the interim period.

### *DIRECT REFERRAL TO CCS*

If providers wish to contact CCS directly, the following information is required:

1. Patient name
2. Date of birth
3. Medi-Cal member identification number
4. Name, address, and telephone number of the parent/legal guardian
5. Address and telephone of the child, if different
6. Medical condition
7. Referring provider's name and phone number
8. Medical notes, which must include a plan of treatment

The information may be faxed or mailed to CCS. Identify the specialist for referral if one has been selected. CCS will honor the request if the physician is CCS-paneled. Referrals should be made to specialists in the Alliance network who are also CCS paneled.

| **CALIFORNIA CHILDREN SERVICES (CCS)** |
|---|
| 1000 Broadway, Suite 5000<br>Oakland, CA 94607<br>Phone Number: **1.510.208.5970**<br>Fax: **1.510.267.3254** |

Providers should also forward copies of medical reports that support the CCS-eligible condition or suspected condition. In addition to a history and physical, these might include laboratory test results, diagnostic imaging reports, and operative reports or pathology findings.

### *COORDINATION OF CARE*

PCPs are required to coordinate services with CCS specialty providers. If the member is eligible for CCS services, CCS will provide medical case management for the specific CCS condition. In all cases, PCPs must continue to provide primary case management to the member. Children with CCS-eligible conditions should still see their PCP for routine care, urgent care of non-eligible conditions, and for preventive care, including immunizations.

### *CLAIMS*

If the specialist has received CCS authorization for services, the specialty provider should submit claims for payment directly to the county CCS program. If CCS eligibility is pending or denied, specialty providers can send claims for care authorized by the Alliance or referred by an Alliance provider to the Alliance Claims Department. Upon CCS authorization, the Alliance will forward the claim to CCS.

## Dental Screening – Medi-Cal (Health Care Services)

Dental screening is a component of a comprehensive health assessment for all members. PCPs should refer Medi-Cal members **0-20 years** of age to fee-for-service (FFS) Medi-Cal Dental Program providers. Members may also self-refer to dental services.

### *IDENTIFICATION, DOCUMENTATION, AND REFERRAL FOR CHILDREN*

Dental screening for children is a required component of an oral exam. Mouth and teeth should be assessed, and referrals made as follows:

1. For children younger than **three (3) years old**, make a dental referral if any problems are suspected.
2. For children **3-20 years old**, ask the family/guardian if the child has seen a dentist in the past **12 months**. A referral should be made if the child has not seen a dentist or a problem is identified.

### *IDENTIFICATION, DOCUMENTATION, AND REFERRAL FOR ADULTS*

Medi-Cal does not pay for dental care for adults **21 years of age** and older. PCPs should still assess whether adult patients have seen a dentist in the past **12 months**. If not, adult patients should be encouraged to find a dentist who provides low-cost dental care. For more information, please call the Medi-Cal Dental Program toll-free at **1.800.322.6384**.

### *TOPICAL FLUORIDE VARNISH*

Topical fluoride varnish is a benefit for Medi-Cal children younger than **six (6) years of age**, up to three (3) times in a **12-month** period. In addition to dentists, physicians, nurses, and medical personnel are permitted to apply fluoride varnish when the attending physician delegates the procedures and establishes protocol.

### *CARVE-OUT DRUGS COVERED BY FEE-FOR-SERVICE MEDI-CAL*

The California Department of Health Care Services (DHCS) covers certain drug classifications and are considered non-capitated to the Medi-Cal managed care (the Alliance) plan, in other words they are carved out of the Plans (the Alliance) responsibility.

For Medi-Cal members, the Alliance is not responsible to cover drugs under the below listed drug classifications in a professional, outpatient, or inpatient setting, and would need to be billed to Fee-For-Service (FFS) Medi-Cal.

- Antivirals (HIV/AIDS/Hepatitis B) Drugs;
- Alcohol and Heroin Detoxification and Dependency Treatment Drugs;
- Blood Factor: Clotting Factor Disorder Treatment Drugs;
- 
- Psychiatric/Antipsychotic Drugs.

These drugs should be billed to Fee-For-Service (FFS) Medi-Cal.

The Alliance routinely reviews the above listed drug classifications to make changes to our claim and authorization system and processes to ensure we are in alignment with the DHCS requirements.

We encourage providers to review drugs in this classification provided to Alliance Medi-Cal members to ensure they are submitted directly to FFS Medi-Cal. May result in delays or denial of non-payment from the Alliance. For more information, please refer to the additional resources below.

Medi-Cal billing manual, MCP: Single Plan publication:

https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/11F02F0E-1773-4278-90B3-B934358F0D45/mcpsingle.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

DHCS All Plan Letter 16-004, Medi-Cal Managed Care Health Plans Carved-Out Drugs:

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-004.pdf

## Tuberculosis (TB) Control Services (Health Care Services)

### *CLINICAL GUIDELINES*

Providers should follow the guidelines of the American Thoracic Society in the provision of TB services. The Mantoux tuberculin test is the only screening test to be used.

Alliance providers must identify, refer, and coordinate services with the Alameda County Health Care Services Agency, Division of Communicable Disease Control and Prevention, or Directly Observed Therapy (DOT) or Directly Observed Preventive Therapy (DOPT) for tuberculosis. All suspected or confirmed TB cases should be reported to the TB Controller.

### *REPORTING*

Per Title 17 of the California Code of Regulations, providers must promptly report all suspected or confirmed TB cases to the TB Controller within **one (1) day** of identification.

A completed Confidential Tuberculosis Report must be faxed to:

Tuberculosis Controller
Division of Communicable Disease Control and Prevention
Phone Number: **1.510.577.7000**
Fax: **1.510.577.7024**

### *REFERRAL CRITERIA*

Some TB patients may require more medical management than typically provided by a PCP.

Patients meeting any of the following criteria require a referral DOT or DOPT when there is suspected or diagnosed TB:

- Adverse reaction to TB medications
- Any patient the physician or nurse case manager deems at risk for noncompliance
- Children and adolescents
- Demonstrated drug resistance to either Isoniazid or Rifampin
- History of drug or alcohol abuse
- History of previous TB treatment
- Homeless or shelter residents
- Immunocompromised, or at risk of being immunocompromised
- Individuals demonstrating non-compliance
- Living in a home with another case of DOT
- Major psychiatric, memory, or cognitive disorder
- Patients on intermittent therapy
- Patients whose treatment has failed, who have relapsed after completing a prior regimen, or who demonstrate slow sputum conversion or clinical improvement
- Poor or non-acceptance of TB diagnosis
- Smear and culture positive **three (3) months** into therapy
- Too ill for self-management

Document the referral to DOT/DOPT in the member's medical record.

### *HOSPITAL DISCHARGE*

Providers must notify the TB Control Unit at **1.510.208.5940** at least **24 hours** prior to the anticipated hospital discharge of a member who is a TB suspect/case. Fax a completed TB Discharge Treatment Plan to **1.510.628.7898**.

## Medi-Cal Rx – Outpatient Pharmacy Benefit (Medi-Cal Only) (Health

## Care Services/Pharmacy)

Effective Saturday, January 1, 2022, the Medi-Cal pharmacy benefit is covered by the Department of Health Care Services (DHCS). The Alliance will no longer cover outpatient pharmacy. All providers will be required to use the Medi-Cal Rx Portal to submit authorizations for medications that require authorization and receive payment for these claims. The new program will be called “Medi-Cal Rx.”

Individual prescribers will each need to register to the Medi-Cal Rx portal to be a user by:

1. Visiting **www.medi-calrx.dhcs.ca.gov**
2. Clicking on “Provider Portal”
3. Then click on “Register”

Once registered, providers will receive a PIN in the mail to the address used when they signed up through the Medi-Cal Rx portal. It could take up to **three (3) months** to receive a PIN in the mail. Once received, the rest of the Medi-Cal Rx registration process may be completed online using the assigned PIN.

### *MEDI-CAL RX APPEALS*

Providers will be able to submit appeals for prior authorization denials, delays, and modifications through the Medi-Cal RX portal once they have registered or by mail to:

Medi-Cal CSC, Provider Claims Appeals Unit
PO Box 610
Rancho Cordova, CA, 95741-0610

Member appeals will be handled through a State Fair Hearing by the California Department of Social Services. This process is different from the appeal process you may have used with the Alliance. In a State Hearing, a judge reviews the request and makes a decision.

The State Hearing Request Form is available at **www.dhcs.ca.gov/services/medi-cal/pages/medi-calfairhearing.aspx**. Instructions and additional options can be found on the DHCS website.

# Section 16: Health Education (Health Ed)

Health education services are important benefits that the Alliance offers to providers and members. This section outlines some of the available services.

## Health Education Services (Health Ed)

The Alliance offers health education services to Alliance members at no cost. Alliance-sponsored classes, materials, and self-management programs help members achieve healthy lifestyles, prevent illness and injury, and manage health conditions. The Alliance partners with many local organization and providers to offer health education services. Programs and handouts are designed to meet the cultural, linguistic, and health literacy needs of our members. Providers can find a listing of health education offerings and community referrals in our Provider Health Education Resource Directory on the Alliance website at **www.alamedaalliance.org/providers/patient-health-wellness-education**.

Alliance Health Programs currently offers the following:

- Enrollment for eligible members into a CDC-approved Diabetes Prevention Program (DPP).
- Interpreter services and transportation for members who attend health education classes sponsored by the Alliance.
- Patient handouts on many health topics in English, Spanish, Chinese, Vietnamese, and Tagalog.
- Referrals to classes or groups on diabetes, hypertension, CPR/first aid, weight management, pregnancy/breastfeeding/childbirth, and parenting.
- Referrals for one-on-one support with diabetes, asthma (adults and children), hypertension and breastfeeding.

There are many ways to request health education services:

- Call Alliance Health Programs at **1.510.747.4577**
- Download materials and forms at **www.alamedaalliance.org/live-healthy**
- Members can mail the Member Wellness Programs and Materials Request Form
- Providers can fax the Provider Wellness Programs and Materials Request Form

Our programs often change to ensure we meet the needs of our members and providers. Please contact us to receive the most current information:

Alliance Health Programs
Phone number: **1.510.747.4577**
Email: **livehealthy@alamedaalliance.org**
**www.alamedaalliance.org/providers/patient-health-wellness-education**

# Section 17: Serving Your Diverse Population (Health Ed)

Alameda County is culturally diverse, and residents speak a wide variety of languages. This section will help you provide Alliance members with culturally and linguistically appropriate services.

In accordance with the US Code of Federal Regulations, Title 42, CFR Section 440.262, we ask that all Alliance providers promote access and delivery of service in a culturally sensitive manner to all patients, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. These methods must ensure that patients have access to covered services that are delivered in a manner that meets their unique needs.

The Alliance is committed to providing language assistance in the member's preferred language, including American Sign Language (ASL), and effective communication for individuals with disabilities. This section outlines how language preferences are identified and the requirements for providers with respect to language access and documentation.

### *TITLE VI COMPLIANCE*

Alliance providers must comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d and 45 C.F.R. Part 80). Title VI prohibits recipients of federal funds, such as Medicare/Medi-Cal providers, from discriminating against persons based on race, color, or national origin.

In accordance with Title VI, all Alliance providers (PCPs, ancillary, specialty, and inpatient providers) must provide access to services in the member's language at all points of contact. At no time should a provider rely on translation or interpretation services from a member's family members or friends, unless the member insists, and the use of a non-qualified interpreter is documented.

When a member selects a provider who does not speak the member's language, the provider is still obligated to meet the member's language needs in compliance with Title VI by utilizing in-house bilingual and/or bi-cultural staff, using over-the-phone or video interpreter services, or scheduling in-person services for American Sign Language (ASL), complex, or highly sensitive appointments. These services are provided at no cost to the member.

## Documenting Staff Language Proficiency (Health Ed)

All Alliance providers must keep documentation of the language proficiency for all their clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English. Documentation should include demonstration of

proficiency in both English and the other language(s) being assessed and fundamental knowledge of health care terminology and concepts relevant to health care delivery systems in English and other language(s) being assessed.

## Signage for Interpreter Services (Health Ed)

Providers should have multilingual signage available for non-English-speaking patients. This will help providers and office staff identify which languages Alliance members speak. The Alliance can provide providers with a sign for use in their office that states: "Point to your language! We will get you an interpreter" in multiple languages. For a laminated copy, please call the Alliance Provider Services Department at **1.510.747.4510**.

If a provider is unable to offer language access for the member through their office's own resources, the Alliance will assist with interpreter services at no cost to the provider or member. Please refer to "Requesting Interpreter Services" in this section.

### *QUALIFIED MEDICAL INTERPRETER SERVICES*

The Alliance provides interpreter services that include telephonic, video, or in-person interpretation when a provider cannot meet the language needs of an Alliance member. These interpreter services are used during discussions of medical and non-medical information. Hospitals are required to provide interpreter services to patients.

At the time of scheduling the medical appointment, please ask the patient (or the minor patient's parents) what their preferred language is for speaking and reading. When an Alliance member's language needs cannot be met by the provider, please offer to coordinate interpreter services. Please document the members' preferred language and any refusal of qualified interpreter services in the medical chart.

## Requesting Interpreter Services (Health Ed)

The Alliance provides no-cost interpreter services including ASL for all Alliance-covered services, 24 hours a day, 7 days a week. Please confirm your patient's eligibility before requesting services.

### *TELEPHONIC INTERPRETER SERVICES*

Common uses for telephonic interpreter services:

- Administrative communications with patients
- Allied health services such as physical, occupational, or respiratory therapy
- Freestanding radiology, mammography, and lab services
- Routine and follow-up clinic visits

To access telephonic interpreters, please follow the steps below:

1. Please call **1.510.809.3986**, available 24 hours a day and 7 days a week.
2. Enter your PIN:
    - Other Alliance providers – press **1004**

   - Alameda Health Systems –**1005**
   - Behavioral health care – press **1003**
   - Children First Medical Group (CFMG_ – press **1002**
   - Community Health Center Network (CHCN) – press **1001**
3. Say or enter the language you need:
   - Spanish – press **1**
   - Cantonese – press **2**
   - Mandarin – press **3**
   - Vietnamese – press **4**
   - For all other languages – press **0**
4. Provide the nine (9)-digit Alliance member ID number.

For communication with a patient who is deaf, hearing, or speech impaired, please call the California Relay Service (CRS) at **711.**

### *TELEHEALTH AND VIDEO INTERPRETER SERVICES*

When you are ready to connect with a telephonic interpreter during a telehealth visit, please follow steps 1-4 above. Provide the telehealth phone number and login information to the interpreter. The interpreter will then call in to join your telehealth visit. For more information about video interpreters and telehealth visits using online platforms, please email **interpreters@alamedaalliance.org**.

### *IN-PERSON INTERPRETER SERVICES*

Members can receive in-person interpreter services for the following:

- Sign language for the deaf and hard of hearing.
- Complex courses of therapy or procedures, including life-threatening diagnoses (e.g., cancer, pre-surgery instructions, and evaluation or reevaluation for physical or occupational therapy, chemotherapy, transplants, etc.).
- Highly sensitive issues (e.g., sexual assault/abuse, end-of-life, and initial evaluation for behavioral health, etc.).
- Other conditions by exception. Please include your reason in the request.

If the appointment requires an in-person interpreter, please follow these steps to request:

1. You must request in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
2. You can complete the online Interpreter Services Request Form on the Alliance Provider Portal or download the fillable form on the Alliance Website:
   - Online form:
     - Visit the Alliance website at **www.alamedaalliance.org**.
     - Click on the ‘Provider Portal’ link in the upper right-hand corner, then log in.
     - Look up your patient’s eligibility, then click on the link at the top of the eligibility page to access the online form.
   - Fillable form:

- Visit the Alliance website at **www.alamedaalliance.org/language-access**.
- Download the Interpreter Services Request Form.
- Complete and fax the form to **1.855.891.9167**.

If you need to revise a request, please cancel the original request and submit a new one. The Alliance will notify providers by fax or phone if for any reason we cannot schedule interpreter services.

If needed, please cancel interpreter services at least **48 hours** prior to the appointment by calling the Alliance Provider Services Department at **1.510.747.4510**.

### *TRANSLATION OR ALTERNATE FORMAT OF ALLIANCE DOCUMENTS*

Members can also request written member materials in a language or format they need. All vital Medi-Cal Alliance materials are offered in English, Spanish, Chinese, Vietnamese, and Tagalog. Vital Group Care materials are offered in English, Spanish, and Chinese. Members can call the Alliance Member Services Department to request materials in their preferred language, or materials in audio, Braille, large print, or other alternative formats.

Professional medical interpreter services, written translation, and alternate formats of plan member literature are available to Alliance members at no cost. Auxiliary aids are also available to Alliance members' authorized representatives, or someone involved in the member's healthcare.

Members may request language assistance, translations, alternate formats, and auxiliary aids by calling:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
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**

### *MATCHING MEMBER AND PRIMARY CARE PROVIDER LANGUAGE*

Members may select their PCP by language using the Provider Directory. The Provider Directory identifies the language capabilities available in the provider office. Alliance members are encouraged to choose their own PCP. However, if a member does not choose a PCP within 30 days of becoming an Alliance member, one will be chosen for the member through auto-assignment. If auto-assignment is necessary, the Alliance makes every effort possible to match the member's preferred language with the provider office's language capabilities.

## Cultural and Linguistic Provider Training and Development (Health Ed)

### *CULTURAL SENSITIVITY TRAINING*

All Alliance providers and clinic staff are required to complete sensitivity training as a part of the new provider orientation and annually thereafter to keep staff updated on best practices and changing member demographics and needs.

The training includes:

- Cultural competency/sensitivity.
- Diversity among the Alliance's member population.
- Provider and member resources to include language assistance services and translated materials.
- Best practices for providing health care services to members with limited English proficiency, diverse cultural and ethnic backgrounds, seniors and persons with disabilities (SPDs), and diverse gender, sexual orientation, or gender identities.
- How structural and institutional racism and health inequities impact members, staff and network providers.

The Alliance's Cultural Sensitivity Training is updated annually and available online at **www.alamedaalliance.org/providers/provider-resources/training-and-technical-assistance-opportunities**. Providers can also request a copy by calling the Alliance Provider Services Department at **1.510.747.4510**.

Providers and office staff who need help locating culturally and linguistically appropriate health education materials and programs can call Alliance Health Programs at **1.510.747.4577**.

## Monitoring Cultural and Linguistic Access and Quality of Care (Health Ed)

One of the Alliance's goals is to evaluate, implement, and integrate cultural and linguistic competency across plan operations in order to create a culturally competent organization, increase access to care, enhance the quality of care and health outcomes, maximize patient satisfaction and retention, and reduce health disparities. Measuring and improving cultural competency is a key factor in reducing sociocultural barriers to health care. The ultimate goal is to increase the quality of care for all Alliance members, with an emphasis on reducing health disparities for our largest ethnic and language groups.

The Alliance monitors cultural and linguistic access and quality of care through member surveys, membership data, claims data, special studies, site reviews, complaint data, and quality indicators.

### *FACILITY SITE REVIEWS (FSR)*

During PCP facility site reviews (FSR), Alliance staff will evaluate:

- Whether providers are recording the member's preferred language in medical records or on a computerized system.

- The procedures followed when serving a member whose preferred language is not English.
- Whether persons providing language interpreter services, including American Sign Language, are trained in medical interpretation.
- Whether site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities, and whether a written policy is in place.
- The provider's system for scheduling members who require interpretation services.
- The availability of patient literature and signs in languages other than English.

***REVIEW OF QUALITY INDICATORS***

The Alliance examines culture and language as elements in its quality studies. These studies allow the Alliance to identify patterns of use that may indicate unmet cultural and linguistic needs.

Results are used to help the Alliance and its providers develop services that meet members' cultural and linguistic needs.

# Section 18: Transportation Services (CMDM)

This section contains information on the transportation benefits covered by the Alliance.

## Transportation Benefits (CMDM)

The Alliance provides the following transportation benefits to Medi-Cal members for all medically necessary services covered by the Alliance:

- Emergency medical transportation (EMT)
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)

The Alliance provides the lowest-cost modality of transportation that is adequate for the member's needs. The Alliance will only provide transportation services that were approved by the Alliance and its transportation vendor.

The following guidelines will be used when reviewing requests for transportation services:

- **Emergency medical transportation (EMT)** is provided when a member's medical condition is acute and severe, necessitating immediate medical diagnosis to prevent death or disability. Requests do not require prior authorization.

  The following guidelines apply to EMT:

  - Emergency medical transportation by air is covered only when medically necessary and when other forms of transportation are not practical or feasible for the patient's condition.
  - Ground emergency medical transportation is covered when ordinary public or private medical transportation is medically contraindicated, and transportation is needed to obtain care.
  - Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient.
  - Medical transportation, which represents a continuation of an original emergency transportation event does not require prior authorization.

- **Non-emergency medical transportation (NEMT)** is covered for all medically necessary Medi-Cal services covered by the Alliance. The Alliance shall provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. NEMT is provided for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Alliance shall ensure door-to-door assistance for all members receiving NEMT services.

The Alliance shall ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with the Department of Health Care Services (DHCS).

Requests for NEMT transportation services must meet the following requirements:

- To determine the appropriate level of service, the treating physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender (PA or NP) must complete and sign the Alliance Physician Certification Statement (PCS) Form approved by the Department of Health Care Services (DHCS).
  - The PCS Form collects data regarding the member's functional limitations, prescribed dates of service, and prescribed mode of transportation. The provider must also attest that medical necessity was used to determine the type of requested transportation. The provider must document the member's functional limitations justification on the PCS Form to provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicle.
  - The PCS form must be completed **before** NEMT services can be provided to the member. The PCS form includes the certification statement (prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested). The signed PCS form with the required fields will be considered completed.
    - Based on medical necessity, a provider may prescribe NEMT for up to **12 months** for members.

    The completed PCS Form must be submitted to:

    Alliance Case and Disease Management Department
    Phone: **1.510.747.4512**
    Email: **deptcmdm@alamedaalliance.org**
    Fax: **1.510.747.4130**

  - Once the completed PCS Form is received by the Alliance, it may not be modified. The Alliance and its transportation vendor coordinate with the prescribing provider to ensure the PCS Form submitted captures the lowest-cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs.
  - The Alliance captures data from the PCS Form for reporting and submitting the data to the DHCS.

NEMT is also provided for a parent or guardian when the member is a minor. The

Alliance provides transportation for unaccompanied minors with the written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

NEMT is provided in the following modalities and situations:

- NEMT ambulance services are provided for:
  - Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.
  - Transfers from an acute care facility to another acute care facility. Members transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate licensed care facility. These NEMT services do not require the PCS form.
  - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
  - Transport for members with chronic conditions who require oxygen when monitoring is required.
  - Advanced Life Support services are provided when the member requires a paramedic during transport.
  - Critical Care Transportation/Specialty Care Transportation services are provided when the member's condition requires cardiac monitoring.
  - Life Support (LS) services are provided when the member's condition requires oxygen that is not self-administered or regulated.
- Litter / Gurney van services are provided when the member's medical and physical condition does not meet the need for NEMT ambulance services but meets both of the following:
  - Requires that the member be transported in a prone or supine position because the member is incapable of sitting for the period of time needed to transport.
  - Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs, or other forms of public conveyance.
- Wheelchair van services are provided when the member's medical and physical condition does not meet the need for litter van services but meets any of the following:
  - Renders the member incapable of sitting in a private vehicle, taxi, or other form of public transportation for the period of time needed to transport.
  - Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.

        - Requires specialized safety equipment over and above that is normally available in passenger cars, taxicabs, or other forms of public conveyance.
    - NEMT by air is provided only when transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician or mid-level provider.

  For Medi-Cal services not covered by the Alliance, including specialty mental health substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system or California Children's Services (CCS), the Alliance will make its best effort to refer and coordinate NEMT for members whose condition necessitates one of the above forms of transportation.

- **Non-medical transportation (NMT)** is covered for all round-trip transportation to medically necessary services covered by Medi-Cal. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances. Requests are submitted to and processed by the Alliance's transportation vendor. The Alliance shall provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

  The Alliance does not require prior authorization for NMT services, unless over **50 miles** in one (1) direction.

  NMT is also provided for a parent or guardian when the member is a minor. The Alliance provides transportation for unaccompanied minors with the written consent of a parent or guardian or when applicable state or federal law does not require parental consent for the minor's service.

  NMT coverage includes transportation costs for the member and one (1) attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation. This must be requested at the time of the initial NMT request.

  NMT is provided using the lowest-cost modality appropriate for the member's condition.

  NMT modalities include the following:

    - Public transportation/mass transit
    - Paratransit
    - Taxicab/curb-to-curb passenger vehicle
    - Door-to-door passenger vehicle

- Any other form of private conveyance (private vehicle), including mileage reimbursement consistent with the IRS rate for medical purposes when conveyance in a private vehicle is arranged.

Members seeking NMT must attest to the Alliance's transportation vendor in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member does not have a valid driver's license, no working vehicle available in the household, is unable to travel or wait for medical or dental services alone, or has a physical, cognitive, mental, or developmental limitation.

In order to receive gas mileage reimbursement for the use of a private vehicle (driven by someone other than member), members must first inform transportation vendor of intent to use private vehicle for upcoming NMT. After the NMT occurs, the following documentation must be submitted to the Alliance's transportation vendor in compliance with all California driving requirements, including:

- Valid driver's license;
- Valid vehicle registration; and
- Valid vehicle insurance

NMT services for Medi-Cal carved-out services will be provided upon the member or provider's request to the Alliance. NMT can continue to be provided through Medi-Cal FFS agencies, such as CCS if requested directly to the agency.

## Transportation Liaison (CMDM)

The Alliance Transportation liaison is available to members and providers to ensure eligible transportation requests are scheduled.

You can reach the transportation liaison at 510-373-5654.

# Section 19: Formulary and Pharmacy Services (Group Care Only) (Health Care Services/Pharmacy)

This section covers how to obtain pharmacy services for Group Care members only. Please refer to section 12: Out-of-Plan Services for information on the pharmacy benefit for Medi-Cal members.

The Alliance subcontracts with a Pharmacy Benefit Manager (PBM) for select pharmacy services through PerformRX LLC (PerformRX).

The role of PerformRX in the Alliance Group Care network includes:

- Conducting online Drug Utilization Evaluation (DUE) programs at the point of sale
- Developing and leading the drug class reviews in the Pharmacy & Therapeutics (P&T) committee meetings
- Managing the pharmacy network
- Monitoring and reporting drug utilization patterns
- Processing initial prior authorization and exception requests
- Processing pharmacy claims

Providers and pharmacies are encouraged to contact PerformRX for questions related to prior authorizations and claim transactions. The most current contact information, operating hours, and operating manual related to PerformRX are located online at **www.alamedaalliance.org**.

## Formulary (Health Care Services/Pharmacy)

The Alliance maintains a formulary (Preferred Drug List) for Group Care members for the outpatient prescription benefit (also known as a retail pharmacy benefit). The formulary lists drugs available to Alliance Group Care members without the need for a prior authorization (PA) request.

The Alliance P&T Committee is responsible for the development of the formulary using sound clinical evidence. Therapeutic classes in the formulary are reviewed at least annually by the P&T Committee. The P&T Committee consists of the Alliance Chief Medical Officer (CMO) or designee, Alliance Director of Pharmacy, licensed practicing pharmacists, and licensed practicing physicians from the community. The group meets at least quarterly.

Updates to the formulary are communicated online to both members and providers. Providers may request changes to the formulary. Requests for changes are reviewed during the P&T meeting the following quarter.

The Alliance P&T Committee uses the following criteria in the evaluation of drug selection for its formulary:

- Comparable cost and outcomes of the total cost of drug and medical care
- Comparison of relevant drug benefits to current formulary drugs of similar use, with a goal of minimizing duplication
- Drug effectiveness
- Drug efficacy
- Drug safety profile

### *FORMULARY CATEGORIES*

There are five (5) drug dispensing categories on the Alliance formulary, including restrictions and preferences:

1. **Formulary Drugs**
   Drugs on the formulary are preferred and may or may not require prior authorization for claim adjudication.

   When covered, the drugs may also have one (1) or more of the following restrictions:

   - Generic Substitution – The generic equivalent has to be dispensed when available.
   - Biosimilar substitution required for bioidentical biosimilars
   - Quantity Limits – A limit on the quantity and/or duration of therapy.
   - Step Therapy – Requires one (1) or more of a prerequisite first step drug to be tried before progressing to a second step drug.
   - Age Restriction – Restriction to a specific age when medically appropriate for the drug.

   Providers can refer to the comprehensive formulary for further explanation and a list of specific drugs that are subject to generic substitution and step therapy or have quantity limits or age/gender restrictions.

2. **Therapeutic Interchange**
   Therapeutic interchanges promote rational pharmaceutical therapy when evidence suggests that clinical outcomes are comparable when substituting a drug that is therapeutically equivalent but chemically different from the prescribed drug. The substituted drug may be of a different drug class but has comparable effectiveness.

   Therapeutic interchange protocols are never automatic and require authorization from the prescribing provider.

3. **Drugs Requiring Prior Authorization**
   Non-formulary drugs subject to prior authorization require approval from the Alliance or the PerformRX Authorization Department for the Group Care line of business. The prior authorization review process serves as a quality measure to

ensure the drug is safe and cost-effective. To review requests for the outpatient pharmacy benefit, the Alliance and PerformRX uses drug treatment guidelines (criteria), reviewed and approved by the P&T Committee.

If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires prior authorization or exception.

4. **Drugs Requiring Exception**
   Non-formulary drugs can also be requested and processed as an exception. An exception is similar to a prior authorization except the Alliance does not have drug review guidelines (criteria) to guide the clinical reviewer, or the requested drug exceeds the scope of coverage (see Non-Formulary Drugs below). Rather, approval will be based on evidence of medical necessity on a case-by-case basis.

   The exception review process serves as a quality measure to ensure the drug is safe, cost-effective, and medically necessary. The PerformRX Prior Authorization Department for the Group Care line of business will forward all exception requests to the Alliance to be reviewed by a licensed pharmacist or physician. Providers can request an exception authorization by submitting a Prescription Drug Prior Authorization (PA) Request Form to PerformRX per the exception protocols.

   Please contact PerformRX for inquiries on any of the above formulary categories or to submit a verbal or written prior authorization or exception request. The most current contact information is located online at **www.alamedaalliance.org**.

3. **Emergency Supply**
   In compliance with state rules, the Alliance will cover a **three (3)-day** supply of medication for Alliance members in emergency situations. This policy applies to medication that normally would require a Prescription Drug PA Request or exception request.

   Emergency situations include:

- A recent discharge from an emergency room (ER)
- A recent discharge from the hospital
- Any event that involves an imminent and serious threat, including (but not limited to) severe pain, potential loss of life, limb, or major bodily function

Contracted Alliance pharmacies can help Alliance members obtain an emergency supply. Alliance members can find a list of pharmacies that work with us in the Alliance Provider Directory or online Pharmacy Search.

After the **three (3)-day** supply is over, providers will need to submit a Prescription Drug PA Request Form. The Alliance will review the request and will inform the doctor of the decision within **one (1) business day**.

***HOW TO ACCESS THE FORMULARY***

Providers can access the Alliance formularies online at **www.alamedaalliance.org**.

## Pharmacy Prior Authorizations and Exceptions (Health Care Services/Pharmacy)

In some instances, a provider may want to prescribe a drug for a member that is not listed on the formulary or does not meet a step therapy restriction, quantity limit, or duration of therapy limits (as listed on the formulary). Providers can submit a prior authorization or exception request to obtain coverage for these drugs.

### *HOW TO REQUEST A PRIOR AUTHORIZATION OR EXCEPTION*

If a drug is not listed as covered on the comprehensive formulary, it can be assumed that it requires prior authorization or exception.

Prescribers can be proactive with obtaining prior authorization or exception approvals to ensure continuity of care. Prescribers do not have to wait until the claim is rejected at the pharmacy to initiate a request. Once the request is received and approved, an authorization will be entered into the pharmacy claims system. The patient can fill the prescription at any network pharmacy without further involvement by the provider or the pharmacist.

Providers should submit a prior authorization or exception request using the Prescription Drug PA Request Form. It is important to document the appropriate clinical information that supports the medical necessity of the requested drug, quantity, refill frequency, and/or duration of therapy. A determination decision will be made within regulatory time frames per the member's line of business. The Prescription Drug PA Request Form can be found on the Alliance website at **www.alamedaalliance.org**.

Prior authorization requests for Group Care can be submitted by fax to PerformRX at **1.855.811.9329** (24 hours a day, 7 days a week) or by calling toll-free at **1.855.508.1713** (Monday – Friday, 8:30 am – 5:30 pm PT).

### *PRIOR AUTHORIZATION AND EXCEPTION REVIEW PROCESS*

All prior authorization and exception requests are initially reviewed by PerformRX for the Group Care line of business. Requests that cannot be approved by PerformRX are forwarded to the Alliance clinical pharmacy staff for review.

The Alliance reviews the request against the following resources:

- Drug request guidelines (approved by P&T Committee)
- Evidence of Coverage (EOC)
- Evidenced-based treatment guidelines
- External specialist review based on medical necessity
- Medical director review based on medical necessity
- Prior use of formulary alternative

### *PRIOR AUTHORIZATION AND EXCEPTION DENIALS*

If a request for prior authorization or exception is denied, the member and requesting provider will be notified by mail and have the right to appeal per the Alliance guidelines as described in Section 19: Grievance and Appeals.

### *EMERGENCY SUPPLY FOR DRUGS REQUIRING PRIOR AUTHORIZATION*

Dispensing pharmacists can dispense up to a **three (3)-day** supply of non-formulary drug(s) using the emergency supply override while waiting to obtain prior authorization for Group Care members. Dispensing pharmacists should only utilize this override for use of alleviation of severe pain and/or treatment of unforeseen medical conditions, which, if not treated immediately, would lead to disability or death. Pharmacies can enter a universal code in the prior authorization field for the override.

For the most current override code, please contact PerformRX or consult the operating manual available online. The use of this code will be monitored.

A Prescription Drug PA Request Form must be submitted to PerformRX by the following business day for approval of the balance of the prescription.

## Pharmacy Network (Health Care Services/Pharmacy)

The Alliance pharmacy network includes most retail pharmacies in addition to a small selection of specialty pharmacies. The pharmacy network serves Group Care members.

### *LOCATING A NETWORK PHARMACY*

To find a nearby Alliance network pharmacy, please visit **www.alamedaalliance.org**.

## Injectables (Health Care Services/Pharmacy)

### *SELF-ADMINISTERED*

Self-administered injectables are dispensed by specialty pharmacies through the pharmacy benefit. The injectables are managed through the usual formulary management process. The Alliance contracts with select specialty pharmacies to provide most of the self-administered injectables and as such, claims will be denied at retail pharmacies unless there is a prior authorization. Some self-administered injectables, like insulin, are listed in the formulary and are handled by retail pharmacies. For the most current specialty pharmacies' contact information and the specialty pharmacy restricted drug list, please visit our website at **www.alamedaalliance.org**.

### *PROVIDER-ADMINISTERED*

Provider-administered injectables can be processed as a medical benefit or as a pharmacy benefit through Alliance specialty pharmacies. Injectables procured directly by the provider should be billed directly to the Alliance as a medical claim. Injectables procured through specialty pharmacies are processed directly through the PBM;

providers do not need to submit a separate claim. Providers are encouraged to use the specialty pharmacies to order the available physician-administered injectables (refer to the specialty pharmacy restricted drug list). The specialty pharmacies can deliver directly to providers' offices. For more information on how to order from specialty pharmacies please visit our website at **www.alamedaalliance.org**.

# Section 20: Clinical Laboratory Services (Health Care Services)

Alliance clinical laboratory services are contracted through Quest Diagnostics, which includes multiple testing sites throughout Alameda County. This section covers how to obtain clinical laboratory services for Alliance members.

## Outpatient Laboratory Services (Health Care Services)

Most outpatient laboratory services must be provided through Quest Diagnostics.

Providers should send members or specimens to Quest Diagnostics for all laboratory testing except:

- Genetic, chromosomal, and alpha-fetoprotein prenatal testing
- HIV testing
- Members who are assigned to the Alameda Health System (AHS) Network*
- Renal tests performed at a dialysis center
- Tests that are included in the PCP capitation contract
- Tests that are provided through alternative sites described on the following pages

***Members with an AHS PCP assignment will use AHS outpatient laboratory facilities.***

### *QUEST DIAGNOSTICS LAB SERVICES*

Quest Diagnostics lab services and programs include:

- Two (2) **four (4)-hour** STAT testing services
- Client services available 24 hours a day, 7 days a week
- Courier service
- Custom ICD-10 Requisition Program
- Quest Express – Same-day testing service
- Supplies

### *QUEST DIAGNOSTIC LAB SERVICES*

For courier service, STAT pickup, or will call, please call toll-free at **1.866.697.8378.**

### *QUEST DIAGNOSTICS CLIENT/PATIENT LAB SERVICES*

Quest Diagnostics representatives are available Monday – Friday, 8 am – 5 pm, toll-free at **1.866.697.8378.**

## Laboratory Procedures in the PCP Office (PS)

### *ASSIGNED MEMBERS*

PCPs may perform certain, specific laboratory tests in their offices. These services need to be documented and submitted to the Alliance. All other tests must be sent to Quest Diagnostics.

### *NON-ASSIGNED MEMBERS*

PCPs who provide laboratory services that are normally capitated to a member who is not assigned to them should submit an FFS claim when:

- Diagnosing or treating a sexually transmitted disease
- Providing family planning services
- Providing minors with consent services
- The services are for a member not assigned to any PCP
- The test has received prior authorization

# Part 3. Care Management

## Section 21: Care Management

### Measuring and Improving Plan Performance (HEDIS®) (QI)

Health Effectiveness Data Information Set (HEDIS®) measures are developed by a national group of health care experts, issued annually, and used as a standard across the country. Using HEDIS® measures, the Alliance can compare its performance against other managed care plans. HEDIS® study methodology and results are also validated and audited by an external agency.

HEDIS® studies use data submitted by providers on their claims/encounter forms and may be supplemented with data retrieved from providers' medical records. The Alliance makes every effort to request records or schedule HEDIS® data retrieval for all studies at the same time and only once each year.

#### *MEDI-CAL QUALITY IMPROVEMENT ACTIVITIES*

In addition to HEDIS® measures, the Alliance has several monitoring responsibilities for its Medi-Cal members. The Quality Improvement Health Equity (QIHE) Program examines data from internal studies in such areas as access (e.g., waiting times for appointments, adequacy of provider network), coordination and continuity of care, utilization, and members' rights. Providers play an important role in our QIHE Program and are required to cooperate with the Alliance quality improvement activities to improve the quality of care and services and member experience. Cooperation includes the collection and evaluation of data and participation in the organization's QIHE programs.

The results of HEDIS® and internal studies for the plan's Medi-Cal members are the basis of planned quality improvement activities. Mandated by the Federal Balanced Budget Act for Medicaid and Medicare health plans, quality improvement activities are aimed at producing statistically significant and sustained improvement in an important aspect of health care delivery or clinical outcome.

An External Quality Review Organization (EQRO) contracted with the Department of Health Care Services validates the Alliance's quality improvement activities. This external review process may also involve requests for member medical records from providers and/or site visits. Providers are required to cooperate with the Alliance quality improvement activities to improve the quality of care and services and member experience. Cooperation includes the collection and evaluation of data and participation in the organization's QIHE programs.

## Alliance Measures of Provider Performance (QI)

Giving providers feedback about their performance in relation to their peers has proven to be a powerful tool to move behavior toward the best practice.

Alliance providers allow the plan to use provider performance data in quality improvement activities and to conduct the Alliance QIHE Program.

The Alliance QIHE Program includes systems to recognize providers based on:

- Partnership behaviors that assist the plan in the measurement and management of health.
- Clinical practices that are linked to improved health outcomes for members.

The data collected from the claims and encounter data are used to measure a provider's clinical practice. The diagnoses and procedure codes documented on these forms are crucial to accurate profiling. Missing, inaccurate, or non-specific codes significantly impact systems such as the reporting of annual HEDIS® measures.

Accurate coding of diagnoses and procedures affects the quality profile.

### *PROVIDER QUALITY REPORT*

As part of the QIHE Program, the Alliance compiles a provider quality report for each PCP undergoing re-credentialing.

The report summarizes a range of provider statistics and activities available from the following areas:

- Member complaints
- Member satisfaction surveys
- Quality reviews
- Site review score

## Care Management Programs (CMDM)

Alliance Care Management Programs coordinate with providers and community partners to improve health outcomes and the integration of care for our members across medical and behavioral health and social services. Care Management Programs address the patient's health care needs across the continuum of care from well-being to end of life, through the identification, assessment, development, and execution of targeted, evidence-based, individualized care plans.

### *PROGRAM GOALS*

- Improve health outcomes for the Alliance patient population
- Identify and document measurable member-specific health goals and plan of care
- Facilitate coordination of care and services to meet member health needs

- Enhance the patient-to-provider relationship
- Reduce unnecessary medical utilization
- Avoid readmissions
- Reduce avoidable emergency department visits
- Manage chronic conditions

***INTERVENTIONS***

Interventions include the following:

- Coordinate with the providers of care about progress toward or lack thereof, the plan of care.
- Assess member needs through Health Risk Assessments (HRAs)
- Develop individualized care plans that address member health and social needs.
- Review and analyze utilization data for opportunities for improved care management and coordination.
- Work in partnership with community agencies and health practitioners who provide case/care management and services to our members.
- Assist members in obtaining measurable health outcome goals through educating and facilitating access to services and community resources.
- Select targeted members for specific Care Management Programs through predictive modeling methodologies.
- Empower and educate members with resources and information to self-manage their health conditions.
- Deliver member-centric coordination of care across the continuum.

***PROGRAMS***

- Care Planning Coordination: HRAs & Care Plans
- Basic Population Health Management (PHM)/Care Coordination
- Complex Case Management (CCM)
- ~~Community Supports~~
- Enhanced Care Management (ECM)
- Disease Management
- Transitional Care Services

## Basic Population Health Management (PHM) (Population Health Management)

The PCP retains primary responsibility for coordinating the member's overall health care and has the responsibility and authority to direct and coordinate the member's services. The Alliance supports the PCP in care coordination by providing the Basic Population Health Management (PHM) program to ensure that needed programs and services are made available to each member at the right time and in the right setting.

***INTERVENTIONS***

Interventions include, but are not limited to:

- Access to primary care
- Care coordination
- Case manager services for children under EPSDT
- Chronic disease programs
- Information sharing
- Navigation and referrals across health and social services
- Programs focused on improving maternal health outcomes
- Services provided by community health workers (CHWs)
- Wellness and prevention programs

## Care Coordination (CMDM)

The Care Coordination Program helps members identify their needs and develop a plan for meeting those needs. Members' needs are identified by HRAs and other member-centric information provided to the Alliance.

### *INTERVENTIONS*

Interventions include, but are not limited to:

HRAs: Assessment of the member's current health and functional status
Care plans: Setting individualized goals and interventions.
Self-management tools
Mailing materials to members based on need.
Member education
Providing mailed and verbal coaching appropriate for the member
Referrals to other Alliance programs when appropriate
Coordinated care both within the Alliance and with community partners.

## Complex Case Management (CCM) (CMDM)

The Complex Case Management (CCM) Program aims to intensively manage and coordinate care for members who have multiple chronic conditions, require extensive use of resources, and need help navigating the system to facilitate the appropriate delivery of care and services. CCM referrals may originate from any source including, but not limited to, self-referral, caregivers, PCPs or specialists, discharge planners at medical facilities, health information line referrals for Group Care members, and internal department referrals such as the Alliance UM Department, and the Alliance Member Services Department.

### *CRITERIA*

CCM criteria include:

- Typically severe degree and complexity of the member's illness.
- Typically intensive level of management necessary.

- Typically extensive amount of resources required for the member to regain optimal health or improved functionality.

The Alliance's goals and intervention schedule for completion shall guide the care manager in managing the case. Additionally, the member shall be provided with the name and number of the CM to contact as needed.

The CM will perform the following:

- Evaluate cultural and linguistic needs, preferences, or limitations.
- Evaluate visual and hearing needs, preferences, or limitations.
- Address the availability of caregiver resources and their involvement with the member.
- Address available benefits and any needs for community and financial resources.
- Provide the member with available programs, resources, and program requirements based upon their and their caregiver's preferences and desired level of involvement in their plan of care.
- Make and follow up on referrals to resources. Follow-up on all referrals will be scheduled at the time of the referral and can be combined as part of the next monthly contact, if not considered urgent.
- Contact the member monthly, at a minimum, or more frequently based on the needs of the member and the referrals made. Each contact includes an assessment of the member's progress toward the goals, an evaluation of the barriers to the goals, and adjusting the care plan and its goals, as needed.
- Continually update and evaluate the Care Plan based on the member's need and using information from ongoing screenings and assessments.

## Community Health Worker (CHW) Services (Housing and Community Supports)

Beginning, Friday, July 1, 2022, community health worker (CHW) services are a Medi-Cal covered benefit.

The California Department of Health Care Services (DHCS) defines CHW services as preventive health services to prevent disease, disability, and other health conditions or their progression; prolong life, and promote physical and mental health. CHWs may include individuals known by several job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

Contracted licensed providers, hospitals, outpatient clinics, local health jurisdiction (LHJ), or community-based organizations may submit claims for CHW services as long as the supervising provider meets the credentialing requirements.. This includes submitting a completed Supervising Provider Attestation for Community Health Workers Form. Please refer to Section 20: Credentialing Process.

For more information on the benefit and/or Medi-Cal billing requirements, refer to the DHCS ALL PLAN LETTER (APL) 22-016 (and any subsequent related APL).

## Enhanced Care Management (ECM) (CMDM)

The Alliance covers Enhanced Care Management (ECM) services for Medi-Cal members with highly complex needs. ECM is a benefit that provides extra services to help members get the care they need to stay healthy. ECM helps coordinate primary care, acute care, behavioral health care, developmental, oral health, community-based long-term services and supports (LTSS), and referrals to available community resources.

If a member qualifies, they may be contacted about ECM services. Members and providers can also call the Alliance to find out if a Medi-Cal member qualifies and how they can receive ECM services.

### *COVERED ECM SERVICES*

Members who qualify for ECM will have their own care team, including a care coordinator to coordinate with members, doctors, specialists, pharmacists, case managers, social services providers, and others to make sure everyone works together. There is no cost to the member for ECM services.

ECM includes:

- Outreach and engagement
- Comprehensive assessment and care management
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family support services
- Coordination and referral to community and social supports

Members can be referred by their provider by calling:

Alliance Case Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4512**
Toll-Free: **1.877.251.9612**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

## Disease Management (CMDM)

The Alliance has four (4) disease management programs based on patient population needs and prevalence. These programs are offered to Alliance members with a diagnosis of asthma, diabetes, high blood pressure, or depression. These programs aim to address gaps in care, prevent complications related to chronic disease, promote health equity, and improve the health and well-being of members. The programs provide education, chronic care management, patient activation, and coordination of care.

All program interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified by claims, pharmacy, and lab data, as well as direct referrals from physicians or community partners.

**Happy Lungs** – Serves members who are 18 years or younger and identified with low-risk asthma based on clinical, pharmacy, and utilization data or direct referral. The members (and their caregivers) will receive an educational letter entitled "Happy Lungs" and an invitation to engage in pediatric asthma services.

**Living Your Best Life with Asthma –** Serves members who are 19 years or older with asthma based on clinical, pharmacy, and utilization data or direct referral. The members will receive an educational letter entitled "Living Your Best Life with Asthma" and an invitation to engage with the Alliance for additional resources.

**Living Your Best Life with Diabetes** – Serves members living with diabetes who are 19 years of age or older and identified based on clinical, pharmacy, and utilization data or direct referral. The members will receive an educational letter and an invitation to access diabetes management programs. Members identified with diabetes at a higher risk of worsening outcomes will also receive an outreach call.

**Living Your Best Life with a Healthy Heart** – Serves members 19 years or older with high blood pressure based on clinical, pharmacy, and utilization data or direct referral. These members will receive an educational letter and an invitation to engage with the Alliance for additional resources. Members identified with high blood pressure at a higher risk will also receive an outreach call.

**BirthWise Wellbeing** – Serves members between the ages of 18-50 who are pregnant or have given birth within the past year. These members will receive an educational flyer on perinatal depression and the Alliance Baby Steps educational materials for a healthy pregnancy. Members will be informed of how they can engage with the Alliance for additional resources. Members identified as higher risk for depression may also receive an outreach phone call.

Providers can refer members by completing and sending the Alliance Case and Disease Management (CMDM) – Program Referral Form. To access the form, please visit the Alliance website at **www.alamedaalliance.org/providers/provider-forms**.
Alliance members may also self-refer.
Please advise Alliance members to call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
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**

## Diabetes Prevention Program (DPP) (Health Ed)

The Diabetes Prevention Program (DPP) is a Medi-Cal benefit that helps eligible members adopt healthy habits, lose weight, and significantly decrease their risk of

developing type 2 diabetes. It is currently not available for Group Care members.

***ELIGIBILITY***

- Patient must be **18 years of age** or older;
- Overweight; and
- At risk for type 2 diabetes.

***PROGRAM DETAILS***

- Members are assigned a lifestyle health coach that helps them set goals and stay on track.
- The first year includes 16 weekly sessions, followed by monthly sessions for the remainder of the year.
- The second year includes monthly sessions if the member achieves attendance and weight-loss goals.
- Members may receive up to $100 in gift cards as an incentive for participating.

The program is only available online. For more details on program eligibility or to view and download the referral form, please visit **www.alamedaalliance.org/providers/patient-health-wellness-education**.

Alliance members may also self-refer.
Please advise Alliance members to call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
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**

Alliance members with Medi-Cal may also take a risk quiz and enroll. Please refer them to the Alliance website at **www.alamedaalliance.org/live-healthy/dpp**. The DPP curriculum is approved by the Centers for Disease Control and Prevention (CDC). The program is available in English and Spanish.

## Transitional Care Services (TCS) (CMDM)

Care transitions are defined as a member transferring from one (1) 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.

Under Population Health Management (PHM) and in line with CalAIM, the Alliance is accountable for providing strengthened Transitional Care Services (TCS) to all members, across all settings and delivery systems. Members are supported from discharge planning until they have been successfully connected to all needed services and supports. This is accomplished by ensuring that a single point of contact can assist members throughout

their transition and ensure all required services are complete.

### *TCS HIGHLIGHTS*

TCS highlights include:

- Connecting the patients to their Alliance PCPs, including facilitating discharge follow-up appointments
- Coordination of care services
- Facilitating referrals to social service organizations
- Facilitating referrals to necessary at-home services
- Medication reconciliation
- Providing education and symptom management
- SUD and mental health treatment referral

You can refer members to Alliance programs through the following:

Case and Disease Management
Phone Number: **1.877.251.9612**
Fax: **1.510.747.4130**
Referral Form: **www.alamedaalliance.org/members/medi-cal/cmdm**

## Infertility Services (Health Care Services)

### *STANDARD FERTILITY PRESERVATION SERVICES*

Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345, and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.557. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

For Medi-Cal members, fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos, are not covered.

## Reconstructive Surgery (Health Care Services)

Reconstructive surgery that is medically necessary is available to beneficiaries.

Reconstructive surgery is “surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (A) to improve function. (B) to create a normal appearance, to the extent possible” (Health and Safety Code § 1367.63m (c) (1) (A) (B)), or (C) to treat gender dysphoria.

Cosmetic surgery, defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance, is not a covered benefit.

ALAMEDA Alliance FOR HEALTH

# Reporting Provider-Preventable Conditions (PPCs) (QI)

## *BACKGROUND*

Beginning Sunday, July 1, 2012, federal law requires that all providers report provider-preventable conditions (PPCs) that occurred during the treatment of Medi-Cal patients. Providers must report all PPCs that are associated with claims for Medi-Cal payment or with courses of treatment given to a Medi-Cal patient for which payment would otherwise be available.

Providers do not need to report PPCs that existed prior to the provider initiating treatment for the beneficiary.

The Federal Affordable Care Act section 2702 and Title 42 of the Code of Federal Regulations, sections 447, 434, and 438 also require that Medi-Cal and Medi-Cal Managed Care plans no longer reimburse providers for PPCs that occur during the treatment of Medi-Cal patients. The Alliance will investigate all reports of PPCs, including those it discovers through any means, to determine if payment adjustment is necessary.

Interested providers may read the State Plan Amendment for PPCs, which took effect Sunday, July 1, 2012.

## *REPORTING REQUIREMENTS*

For Alliance Medi-Cal members, providers must report directly to the Alliance using the PPC reporting form within **five (5) working days** of discovery of the PPC and confirmation that the patient is a Medi-Cal beneficiary. The PPC reporting form is attached and instructions for completing the form are included.

Please submit forms to:

Alliance Compliance Department
Fax: **1.510.373.5999**
Email: **compliance@alamedaalliance.org**

**PLEASE NOTE:** Reporting PPCs for a Medi-Cal beneficiary does not preclude the reporting of adverse events and health-care-associated infections (HAI) to the California Department of Public Health (DPH) pursuant to the Health and Safety Code.

# Section 22: Grievance and Appeals (G&A)

The Alliance maintains a grievance and appeals process under which members may submit their grievance or appeal to the Alliance in accordance with state and federal regulations. The Alliance does not delegate the resolution of grievances and appeals.

Providers are to comply with the grievance and appeals process in accordance with their contract. Failure to comply with our grievance and appeals process may lead to corrective action plans or a possible hold on member assignment.

***DEFINITIONS***

**Grievance** – A written or oral expression of dissatisfaction with regard to the Alliance and/or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by a member or the member's representative.

**PLEASE NOTE:** An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include but are not limited to, questions pertaining to eligibility, benefits, or other managed care plan processes. Where the Alliance is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

**Adverse Benefit Determination** – Defined to mean any of the following actions taken by a managed care plan (MCP):

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure to act within the required time frames for standard resolution of grievances and appeals.
- For a resident of a rural area with only one (1) managed care plan, the denial of the beneficiary's request to obtain services outside the network.
- The denial of a beneficiary's request to dispute financial liability.

**Notice of Action** (NOA) – Also known as a Notice of Adverse Benefit Determination.

**Appeal** – Defined as a review by the Alliance of an Adverse Benefit Determination:

- **Prior Authorization Appeal** – A request to change a prior authorization adverse determination for care or service that the Alliance must approve, in whole or in part, in advance of the member obtaining care or services.

- **Retro Authorization Appeal** – A request to change a prior authorization adverse determination for care or services that have already been received by the member.

### *MEMBER GRIEVANCE PROCESS*

A member may file a grievance:

- Medi-Cal Members – At any time following any incident or action that is subject of their dissatisfaction.
- Group Care Members – Within **180 calendar days** following any incident or action that is the subject of their dissatisfaction.

The Alliance does not discourage the filing of grievances. A member who files a grievance may not be discriminated against, and cannot be disenrolled from the Alliance, the provider group, the provider's office, or the facility in retaliation for filing a grievance.

#### Provider Assistance for Filing Member Grievances

The Alliance is responsible for processing and resolving all grievances. When a provider has become aware that a member is dissatisfied with the delivery of care that has been provided, please provide the following information to the member:

- The member can state that they would like to file a grievance with the Alliance by calling:

  Alliance Member Services Department
  Monday – Friday, 8 am – 5 pm
  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**

- Contracted provider offices or facilities are required to make member grievance forms and assistance readily available in accordance with the California Code of Regulations, Title 28 §1300.68 (b)(7).
- Providers can access the Alliance Grievance Forms by contacting:

  Alliance Provider Services Department
  Phone Number: **1.510.747.4510**
  Email: **providerservices@alamedaalliance.org**
  **www.alamedaalliance.org/providers/provider-resources/grievances-appeals**

### *MEMBER AUTHORIZATION APPEAL PROCESS*

Members or their authorized representative (AR) may request an appeal of an adverse benefit determination. A provider may submit an appeal on behalf of a member for prior authorization and retro authorizations.

When submitting an appeal on behalf of a member, please provide the Alliance Grievance and Appeals Department with a copy of the authorization, denial notification, and all pertinent supporting documentation within:

- **60 days** from the date of denial for Medi-Cal members
- **180 days** from the date of denial for Group Care members

Please mail or fax all information to:

Alameda Alliance for Health
Attn: Grievances and Appeals Department
1240 South Loop Road
Alameda, CA 94502

***FAX: 1.855.891.7258RESOLUTION TIME FRAMES***

In order to provide excellent service to our members, the Alliance maintains processes by which the member can obtain thorough investigation and timely resolution of their grievances with the following process:

**Expedited Grievances**

- Investigation and resolution within **72 hours**.
- Classification of expedited review will be considered for grievances involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

**Standard Grievances**

- Acknowledgement of receipt received in writing or by telephone within **five (5) calendar days.**
- Resolution within **30 calendar days** from receipt of the complaint.

**Expedited Appeals***

- Resolution and written notice within **72 hours**.

**Standard Appeals**

- Acknowledged in writing within **5 calendar days**; and
- Resolved within **30 calendar days** from receipt of the complaint.

*The Alliance may extend the time frame for an expedited appeals resolution by **14 calendar days** in accordance with, and defined by, federal regulations.

For appeals, members have the right to continue receiving benefits pending the resolution of the appeal. Providers may be requested to continue approval of benefits/services pending the final resolution. The Alliance Grievances and Appeals Department will coordinate these requests with the Alliance Utilization Management (UM) Department or the delegate's UM Department.

## *RESOLUTION DETERMINATIONS*

### Grievances

- Resolved – The beneficiary's submitted grievance has reached a final conclusion.

### Appeals

- Uphold – The investigation found the initial determination was correct.
- Overturn – The appeal investigation found the initial determination was not correct and therefore the determination is made to modify or approve the request in favor of the member. The Alliance or its delegate must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the Alliance reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. The Alliance or its delegate shall authorize or provide services no later than **72 hours** from the date it reverses the determination.

## *DELEGATE OR PROVIDER RESPONSIBILITIES*

The Alliance is committed to ensuring thorough research and investigation in addition to compiling all applicable information pertinent to the complaint. As part of the Alliance's investigation, the provider will be required to respond in writing to the complaint and provide medical records if applicable. Written responses are to be received within **10 calendar days** for standard and **24 hours** for expedited cases or if otherwise specified in the request.

## *MEMBERS' RIGHTS – ADDITIONAL ACTIVITIES*

### Member Grievances

The member may also contact the Department of Managed Health Care (DMHC) if they have a grievance about an emergency, a grievance that has not been appropriately resolved by the Alliance, or a grievance that has not been resolved for more than **30 calendar days** for a standard complaint, and **72 hours** if expedited criteria were met.

### Independent Medical Review (IMR)

The member has the right to contact DMHC and request an Independent Medical Review (IMR). Members may request an IMR if they have not initiated a State Fair Hearing (Medi-Cal only) and if the member has already completed the Alliance's grievance process. They may contact the DMHC Health Maintenance Organization (HMO) Help Center for further information toll-free at **1.888.466.2219** or people with hearing and speaking impairments (TDD) at **1.877.688.9891**.

The DMHC HMO Help Center is open 24/7 at no charge to the member. For complaint forms and instructions, please visit the DMHC website at **www.dmhc.ca.gov**.

### Fair Hearing

Medi-Cal members have the right to file a State Fair Hearing with the California Department of Social Services, State Hearings Division. They may contact the State Hearings Division for further information toll-free at **1.800.743-8525** or people with hearing and speaking impairments (TDD) at **1.800.952.8349**. Medi-Cal beneficiaries may also request a State Fair Hearing through the Alameda County Social Services Agency. State Fair Hearings must be requested within **120 calendar days** from the date of the "Notice of Appeal Resolution."

**Ombudsman Assistance**

Medi-Cal members can also request assistance with enrollment and other problems by contacting:

Medi-Cal Managed Care Division Office of the Ombudsman
Monday – Friday, 8 am – 5 pm, excluding holidays
Toll-Free: **1.888.452.8609**
Email: **MMCDOmbudsmanOffice@dhcs.ca.gov**

# Section 23: Credentialing (Credentialing)

All health care providers who contract with the Alliance must have credentials verified through the credentialing process. This section covers the credentialing and re-credentialing requirements providers are expected to meet.

## Credentialing Process (Credentialing)

The Alliance utilizes a credentialing process in order to ensure the participation of quality network providers. The Alliance follows National Committee on Quality Assurance (NCQA) guidelines in conjunction with special credentialing guidelines required by state regulation and policy.

### *DEPARTMENT OF HEALTH CARE SERVICES (DHCS) APL 22-013 SUPERSEDES APL 19-004*

The Alliance follows the regulatory guidance specified in All Plan Letter (APL) 22-013, Provider Credentialing/Re-credentialing and Screening/Enrollment. The APL specifies that managed care plans are required to maintain contracts with their Network Providers (Network Provider Agreement) and perform credentialing and re-credentialing activities on an ongoing basis. The APL also requires the Alliance to perform pre- and post-enrollment site visits to medium- and high-risk providers to verify the information on the application (i.e., comprehensive outpatient rehabilitation facilities, hospice, and home health organizations, independent diagnostic laboratories, independent diagnostic testing facilities, durable medical equipment (DME) suppliers, and prosthetic and orthotic suppliers for initial and re-credentialing applicants).

### *CONFIDENTIALITY*

The information obtained during the credentialing process, whether directly from the provider or from another source, will be treated as confidential information.

### *THE APPLICATION*

Applicants must submit a signed application and supporting documentation to the Alliance. The Alliance then has **180 days** from the signature date on the attestation form to work with the applicant and Credentialing Committee (CC) to complete the credentialing process.

As part of the application process, providers will be asked to attest to statements regarding:

- Reasons for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of disciplinary actions taken against the license

- History of loss of license
- History of convictions
- History of loss or limitation of privileges or disciplinary activity at a facility
- History of professional liability judgments and/or claims that resulted in settlements or judgments paid by or on behalf of the applicant, or pending lawsuits
- Current malpractice insurance coverage

### *COMMUNITY HEALTH WORKERS (CHW) CREDENTIALING*

Contracted providers may submit claims for CHW services as long as the supervising provider has submitted a completed Supervising Provider Attestation for Community Health Workers Form to the Alliance Housing and Community Services Department. The Supervising Provider must be a contracted licensed Provider, hospital, outpatient clinic, local health jurisdiction (LHJ), or a community-based organization (CBO).

### *ADDITIONAL CREDENTIALING STEPS*

#### Facility Site Review

All PCP sites are reviewed by an Alliance Provider Relations representative and Quality Improvement nurse specialists prior to approval as an Alliance provider. For more information, please see Section 24: Facility Site Review (FSR).

#### Recommendation by the Credentialing Committee (CC)

The CC is a standing Alliance committee responsible for credentialing/re-credentialing. The Peer Review Committee (PRC) is responsible for reviewing providers that are identified with quality of care issues.

The CC recommends the approval or denial of an applicant as follows:

- If the recommendation is for **APPROVAL**, the applicant receives written notification of the decision, and the number of credentialed and re-credentialed practitioners are reported monthly, to the Board of Governors in the credentialing summary.
- If the recommendation is for **DENIAL**, the applicant receives written notification of the decision and supporting reasons. If the denial is due to the quality of medical care, the appeal process is included.
-

#### Practitioner Rights

Practitioners have the right to review the information submitted to support their credentialing application, correct erroneous information, receive the status of their credentialing or re-credentialing application, upon request, and receive notification of these rights. Practitioners are notified of these rights in the application cover letter.

Practitioners are allowed access to their credentialing documentation obtained by the

Alliance Peer Review and Credentialing Department to evaluate their credentialing application, attestation, or curriculum vitae (CV) with the exception of National Practitioner Data Bank Reports, references, recommendations, or other peer-review protected information.

Practitioners are notified when credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples of the type of information that would cause the Alliance to alert the practitioner, if there are substantial variations from the practitioner's information, include actions on a license, malpractice claims history, and/or board certification decisions.

The Alliance Peer Review and Credentialing Department staff will contact the practitioner via written request (email or certified mail) of the discrepancy and the practitioner will be asked to submit corrections/explanations within **15 business days** by mail or fax to the Alliance Peer Review and Credentialing Department staff contact.

Right to receive status: Practitioners may contact the Alliance Peer Review and Credentialing Department at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to within **four (4) business days** and the practitioner will be notified of progress in the credentialing process.

## Credentialing Criteria and Basic Qualifications (Credentialing)

The following credentialing criteria are reviewed at initial credentialing and re-credentialing.

### *LICENSE*

All providers must maintain a current license, which is applicable to the provider's scope of practice in the state of California. If providers have or had out-of-state licenses, the status of these licenses shall also be verified for the same qualifications. All initial providers must have an unrestricted license. All provider Medical Board actions are reviewed by the CC.

### *HOSPITAL ADMITTING PRIVILEGES*

All providers must maintain current hospital admitting privileges with unrestricted clinical privileges at a hospital in the Alliance network. The Alliance may waive this requirement if the provider has admitting arrangements in writing through another provider in the Alliance network.

### *DEA CERTIFICATION*

All providers must maintain a current Drug Enforcement Administration (DEA) certification, if applicable to the provider's scope of practice. The Alliance may waive this requirement if the provider's DEA certification is pending, and the provider presents documented evidence that another participating provider in the same office will write all

prescriptions that require a DEA.

### *SPECIALTY BOARD CERTIFICATION*

Specialists applying to the network must be board-certified in the specialty and subspecialty effective Tuesday, July 1, 2003, unless the provider was contracted with the Alliance prior to Tuesday, July 1, 2003. Specialists who have recently completed postgraduate training may be credentialed and will be expected to complete their board certification within the time frame set forth by the American Board of Specialties. If a Specialist is not board-certified in the specialty or subspecialty the practitioner will be reviewed by the CC and considered for network participation based on network needs.

### *NPDB AND HIPDB*

The National Practitioner Data Bank (NPDB) checks medical malpractice claims and the license status for any state in which the physician has practiced. The Healthcare Integrity Protection Data Bank (HIPDB) collects information regarding licensure and certification actions, exclusion from federal and state health care programs, criminal convictions, and civil judgments related to health care.

### *PROFESSIONAL LIABILITY CLAIMS HISTORY*

Information related to malpractice suits and settlements will be collected and reviewed.

### *CLEAR FROM SANCTIONS*

The Alliance does not contract with providers who are excluded or sanctioned from participation in Medicare/Medicaid programs.

### *PROFESSIONAL LIABILITY INSURANCE*

All participating providers must maintain professional liability insurance with limits of liability of at least $1,000,000 per occurrence and $3,000,000 aggregate at all times.

### *WORK HISTORY*

All providers will be reviewed for work history at initial credentialing as obtained through their submitted application or CV.

### *CREDENTIALING AND ALLIANCE EFFECTIVE DATES*

All providers will be entered into our system as a contracted provider once they have been approved through the credentialing process. The effective date is the first of the month following the month that the provider was credentialed.

## Re-Credentialing (Credentialing)

Participating providers are re-credentialed in accordance with Alliance policy. Currently, re-credentialing occurs at least every **three (3) years** or more often as directed by the

CC. The process is similar to the initial credentialing process as outlined earlier in this section.

The following performance areas will be reviewed for all providers, as applicable:

- Member complaints/grievances
- Results of quality reviews
- Facility site review results

### *DENIED RE-CREDENTIALING*

If the CC determines that a provider does not meet re-credentialing criteria, the provider's participation in the Alliance network will be terminated pursuant to the terms of the provider service agreement. From that time onward, the provider may not submit claims to the Alliance for health services provided to Alliance members.

# Section 24: Facility Site Review (FSR) (QI)

All Alliance PCPs will receive periodic facility site reviews (FSRs). This section covers what to expect during a site review.

## FSR Overview (QI)

DHCS mandates initial and periodic FSR and Medical Record Review (MRR) audits for PCP provider sites, and the Alliance complies with this DHCS mandate. The Alliance additionally conducts Physical Accessibility Review Surveys (PARS) for all PCP sites, specialist sites, ancillary services sites, and Community-Based Adult Services (CBAS) provider sites which provide care to a high volume of seniors and persons with disabilities (SPD).

The purpose of FSRs is to ensure that all contracted primary care provider sites:

- Provide appropriate primary health care services to members.
- Carry out processes that support continuity and coordination of care.
- Maintain patient safety standards and practices.
- Operate in compliance with all applicable local, state, and federal laws and regulations.

FSRs are conducted during the initial provider credentialing process. Additionally, site reviews will be conducted as part of the ongoing provider re-credentialing process. This process ensures that each provider continues to meet the Alliance's site review standards. The Alliance Quality Improvement (QI) Department is responsible for conducting site reviews.

## FSR Preparation (QI)

The Alliance will help providers prepare for the review in several ways. Prior to a review, providers will receive a copy of the FSR and MRR tools and standards. To access the FSR Tool, MRR Tool, and other resources, please visit the Alliance website at **www.alamedaalliance.org/providers/provider-resources**.

Providers should review the tools and standards carefully to ensure a successful review. FSR nurses offer provider and office staff training prior to initial facility site reviews and/or upon the provider's request.

The Alliance has developed the Facility Site Review (FSR) and Medical Record Review (MRR) Preparation Checklist to assist you in meeting the standards of the site review. For help preparing your practice for the FSR, please call the Alliance Provider Services Department at **1.510.747.4510**.

***PROBLEMS IDENTIFIED THROUGH FSRS AND MRRS***

If a facility is found to be out of compliance with Alliance and/or state requirements, the provider is notified through the Corrective Action Plan (CAP). For FSRs, a CAP is required for a total score of less than 90%, or for a total score of 90% or above if there are deficiencies in Critical Elements (CE), Pharmaceutical Services, or Infection Control.

For MRRs, a CAP is required for any score below 90%, or any section score below 80% regardless of the total score. A total score of 79% or below for FSRs and/or MRRs will result in a hold on new member assignments as well as follow-up reviews.

Per APL 22-017, the Alliance must not assign new members to providers who do not correct site review deficiencies within established CAP timelines. The Alliance must verify that the PCP site has corrected the deficiencies and that the CAP is closed.

CAP Timeline:

- CE CAP must be submitted within **10 business days** of review.
- FSR/MRR CAP is submitted within **30 calendar days** from the CAP Report. All CAPs must be closed within **90 calendar days** from the date of the FSR and/or MRR report.

The Alliance must remove any provider from the network who does not come into compliance with review criteria and CAP requirements within the established timelines, and the Alliance must expeditiously reassign that provider's members to other providers.

Participation in the Alliance network may be suspended until the facility meets compliance standards. If a provider's non-compliance issues present a clear and immediate danger to patients, the provider's members will be reassigned to another provider in the Alliance network. If problems are documented, providers are allowed time for correction. Failure to provide a timely response will result in a resurvey within **12 months** and/or reporting the provider's site review status to the Alliance's CC. The CC may suspend a provider from plan participation or recommend termination due to non-compliance to the Alliance Board of Governors.

### *DHCS-CONDUCTED FSRS*

DHCS conducts FSRs independently of the Alliance on a small sample of providers in the Alliance network. DHCS does this to monitor the Alliance's compliance with the DHCS contract and to determine how well provider sites are able to implement and meet the standards. DHCS-conducted FSRs may be conducted without prior notice. DHCS will notify Alliance of critical findings within **10 business days** following the date of the FSR and/or MRR and will provide a written report summarizing all DHCS review findings within **30 calendar days** following the review. Within **30 calendar days** from the date of Alliance receipt of the DHCS-conducted FSR report, the Alliance must provide a CAP to DHCS responding to all cited deficiencies documented in the report.

Should a DHCS inspector find a primary care site in substantial noncompliance, the Alliance may suspend that site from plan participation until the facility can meet compliance standards. If the provider's noncompliance issues present a clear and

immediate danger to Alliance members, they will be reassigned to another provider in the Alliance network.

## FSR Tool (QI)

The Alliance utilizes a Facility Site Review (FSR) Tool mandated by DHCS. The FSR Tool contains applicable state requirements. A copy of the full FSR Tool can be found on the Alliance website at **www.alamedaalliance.org/providers/provider-resources**.

The FSR Tool mandates review in the broad areas listed below:

- Access/Safety
- Personnel
- Office Management
- Clinical Services
- Preventive Service
- Infection Control

### *CRITICAL ELEMENTS*

Within the FSR, there are 14 critical survey elements related to the potential for adverse effects on patient health or safety. These critical elements have a weighted score of two (2) points. All other survey elements are weighted at one (1) point.

Critical elements include:

- Exit doors and aisles are unobstructed and egress accessible.
- Airway management equipment (i.e., oxygen delivery system, nasal cannula or mask, bulb syringe, and Ambu bag) appropriate to practice and populations served are present on-site.
- The on-site availability of emergency medicine based on patient population served for anaphylactic reaction management, opioid overdose, chest pain, asthma, and hypoglycemia (i.e., Epinephrine 1 mg/m [injectable], and Benadryl 25 mg [oral] or Benadryl 50 mg/ml [injectable], Naloxone, chewable Aspirin 81 mg, Nitroglycerine spray/tablet, bronchodilator medication [solution for nebulizer or metered dose inhaler], and glucose); appropriate sizes of engineered sharps injury protection (ESIP) needles/syringes, and alcohol wipes.
- Only qualified/trained personnel can retrieve, prepare, or administer medications.
- Office practice procedures provide timely physician review and follow-up of referrals, consultation reports, and diagnostic test results.
- Only lawfully authorized persons dispense drugs to patients.
- Drugs and vaccines are prepared and drawn only prior to administration.
- Personal protective equipment (PPE) for Standard Precautions is readily available for staff use.
- Blood, other potentially infectious materials, and regulated wastes are placed in appropriate leak-proof, labeled containers for collection, handling, processing storage, transport, or shipping.

- Needle stick safety precautions are practiced on-site.
- Staff demonstrates/verbalizes necessary steps/processes to ensure sterility and/or high-level disinfection of equipment.
- Appropriate PPE, exposure control plan, Material Safety Data Sheets (MSDS), and clean-up instructions in the event of a cold chemical sterilant spill are available on-site.
- Spore testing of autoclave/steam sterilizer is completed (at least monthly) with documented results.
- Staff adheres to site-specific protocol and/or manufacturer/product label for management of positive mechanical, chemical, and/or biological indicators of the sterilization process.

### *CRITICAL ELEMENT DEFICIENCIES*

All critical element deficiencies found during a full-scope site survey, focused survey, or monitoring visit must be corrected by the provider within **10 business days** of the survey date, and verified as corrected by the plan within **30 calendar days** of the survey date.

### *HELPING PROVIDERS MEET STANDARDS*

Sites that are non-compliant with the Alliance and/or state requirements are given a **30-day** period to correct identified deficiencies.

## MRR Tool (QI)

The Alliance utilizes an MRR tool mandated by DHCS. The MRR Tool is separate from the FSR Tool.

The MRR Tool and MRR Standards can be found on the Alliance website at **www.alamedaalliance.org/providers/provider-resources**. The MRR Tool contains applicable state requirements. The MRR Tool mandates review in the broad areas listed below.

Please see the full MRR Tool for a detailed explanation of the six (6) criteria listed below:

- Format
- Documentation
- Coordination/Continuity of Care
- Pediatric Preventive Health Care
- Adult Preventive Health Care
- Obstetric/Comprehensive Perinatal Services Program (OB/CPSP) Preventive Criteria

Alliance providers are required to have a medical record for each member. During an MRR, a minimum of 10 member records are audited per contracted provider. Reviewers may request additional records.

## Help and Resources (QI)

The Alliance wants to help all our providers meet the standards. The Alliance Provider Services Department staff and FSR nurses offer guidance and training or refer providers to resources that can help providers meet the established standards. To request assistance, please call the Alliance Provider Services Department at **1.510.747.4510.**

## Provider Initial Review and Fair Hearing Process (CREDENTIALING)

Physicians, ancillary professionals, and other providers shall be entitled to an Initial Review or Fair Hearing and Appeals proceeding when dissatisfied with certain adverse credentialing and/or participation decisions made by the Alliance, including those based on a medical quality concern.

The Initial Review and Fair Hearing process is divided into two (2) phases:

- Phase I – Initial Review: An Initial Review before the Peer Review Committee (PRC) to try to amicably resolve the matter; and
- Phase II – Formal Hearing: For Providers who are dissatisfied with the PRC Initial Review decision and eligible for a Phase II hearing, a formal hearing in front of an impartial Judicial Review Committee (JRC).

### *PROCEDURES FOR INITIAL REVIEW*

The Alliance offers providers an Initial Review when the provider is dissatisfied with an adverse credentialing and/or participation decision made by the PRC. Decisions may include recommendations, such as practice restrictions, denial of the application, or participation in the Alliance network. The provider will be notified in writing of the PRC decision.

The provider may request an Initial Review within **30 days** of receipt of the notice of action or proposed action by PRC. A request for Initial Review must be in writing and must state the basis for the challenge, whether the provider would like to present evidence or oral testimony to the PRC, or both, whether the provider needs special accommodations and any preferred time or dates for the Initial Review within the next **60 days**.

The following procedures are followed for Initial Reviews:

- All credentialing and peer review issues shall be brought before the PRC for review and recommendation.
- Notice will be given to the provider stating the date of the initial review meeting and the provider shall have an opportunity to present their position.
- The decision of the PRC shall be binding and final if the decision was for any reason other than medical quality of care concern.
- If a decision of the PRC is based in whole or in part on medical quality of care concerns, the provider shall have the right to appeal the PRC decision to an impartial JRC through the Fair Hearing process.

### *FAIR HEARING PROCESS*

Providers may request a Fair Hearing if they are dissatisfied with the PRC Initial Review decision and are eligible for a Phase II hearing, a formal hearing in front of an impartial JRC.

### *GROUNDS FOR A FAIR HEARING*

One (1) or more of the following actions, or proposed actions, against a provider by the PRC after the Initial Review shall be grounds for a formal hearing before the JRC:

- Upholding the Alliance's reduction or failure to renew credentialing and/or participation based on medical quality concerns;
- Upholding the Alliance's suspension or imposition of restrictions on credentialing and/or participation for a cumulative total of **30 calendar days** or more in any **12-month** period based on medical quality concerns;
- Upholding the Alliance's denial or termination of credentialing and/or participation based on medical quality concerns.

## Requesting an Appeal (COMPLIANCE & CREDENTIALING)

If the PRC recommends an adverse decision based on medical quality concerns of an initial application or re-credentialing that results in a mandatory reportable action, the practitioner will be notified in writing of this decision. The practitioner has the right to request a hearing before the JRC within **30 days** of receipt of the PRC notification. A provider who wishes, and is eligible, to file an appeal of an adverse credentialing or participation decision must deliver a written notice requesting a fair hearing before the JRC to the Alliance Chief Medical Officer within the time period specified.

The following procedures are followed for a Judicial Review process:

- Fair Hearings shall be brought before the JRC for review and recommendation.
- Notice will be given to the provider stating the date of the JRC and the provider shall have an opportunity to present their position.
- The decision of the JRC will be sent to the PRC and the practitioner.
- The JRC will issue a written decision which shall include findings of fact and a conclusion within **30 calendar days** after the final adjournment of the hearing.

## Requirements for Mid-Level Clinicians (CREDENTIALING)

### *REQUIREMENTS FOR MID-LEVEL CLINICIANS*

PCPs who employ or contract with mid-level clinicians in their practices are responsible for making sure that the clinicians meet the standards set forth by the clinician's licensing authority. The PCP, as the clinician supervisor, is also responsible for developing the protocols under which the clinician will practice. They must meet certain qualifications and standards in order to be credentialed by the Alliance. This helps ensure quality care for members.

### *DEFINITIONS OF MID-LEVEL CLINICIANS*

Mid-level clinicians are non-physician medical practitioners, including:

- Certified Nurse-Midwives
- Nurse Practitioners
- Physician Assistants

### *DEFINITIONS OF BEHAVIORAL HEALTH CARE INTERNS AND ASSISTANTS*

All non-licensed behavioral health providers must be supervised by a licensed behavioral health provider who is contracted with the Alliance and who also follows all California Licensing Board requirements for registration and supervision of non-licensed providers.

These providers include:

- Registered Psychological Associates (PA)
- Registered Associate Social Workers (ASW)
- Registered Associate Marriage and Family Therapist (AMFT) interns

### *CREDENTIALING*

Any mid-level clinician, ASW, AMFT intern, or PA who provides care to Alliance members must be credentialed by the Alliance.

### *LICENSING REQUIREMENTS*

To provide services to Alliance members, mid-level clinicians must have a valid, current license or registration issued by the state of California. Nurse-midwives must be certified by the ACNM Certification Council, Inc. Physician assistants must be licensed in accordance with the requirements of the Physician Assistant Examiners Committee.

### *INSURANCE*

The supervising physician or licensed behavioral health care provider must submit proof that their liability insurance covers the mid-level or non-licensed PA, ASW, or AMFT clinician, or that the clinician has individual coverage.

### *CPR AND ACLS CERTIFICATION*

Mid-level clinicians must maintain CPR certification. They also are encouraged to obtain ACLS certification.

### *PHYSICIAN/CLINICIAN AGREEMENT*

Each physician/mid-level clinician team must sign an agreement stating that the clinician will follow the practice protocols developed by the supervising physician. The agreements, also known as a Delegated Services Agreement and a Supervising Physician's Responsibility document, must be submitted at the time of credentialing and re-credentialing.

***PROTOCOLS***

Protocols must be reviewed and approved by the supervising physician annually. These protocols and any updates must be submitted to the Alliance at the time of credentialing and site reviews

## Organizational Providers (CREDENTIALING)

The Alliance is responsible for verification of the accreditation status, license, certification, and standing with regulatory bodies of all directly contracted organizational providers. This includes but is not limited to, acute care hospitals, freestanding surgical centers, home health agencies, and skilled nursing homes that provide care to Alliance members at the time of contracting and a minimum every **three (3) years** thereafter.

Hospitals, facilities, and organizational providers must meet the following requirements to contract with the Alliance by submitting all licensing and specialty qualification documents to the Alliance for verification as part of the Alliance credentialing and re-credentialing process and demonstrate the ability to meet Alliance requirements as outlined in the Alliance Quality Improvement Health Equity Program Description, Assessment of Organizational Provider Policy, and contract provisions.

***REQUIREMENTS***

- Accreditation or certification reviewed and approved by an accrediting body. If not accredited, the organization must submit a copy of the CMS or state site survey.
- Clear of any sanctions, negative findings, or deficiencies.
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable.
- Completed Alliance application including attestations.
- Current malpractice/general professional liability insurance.
- Eligibility to participate in state and federal programs.
- Valid and current Medicare/Medicaid certification.
- Valid, current, and unrestricted health care/state and business licenses.

# Part 4. Member Rights and Compliance

## Section 25: Member Rights and Responsibilities

As a member of our health plan, each Alliance member is entitled to certain rights.

### Alliance Member Rights (G&A)

1. To be treated with respect and dignity, giving due consideration to their right to privacy and the need to maintain the confidentiality of their medical information.
2. To be provided with information about the plan and its services, including covered services, practitioners, and member rights and responsibilities.
3. To receive fully translated written member information in their preferred language, including all grievance and appeals notices.
4. To make recommendations about the Alliance's member rights and responsibilities policy.
5. To be able to choose a primary care provider within the Alliance network.
6. To have timely access to network providers.
7. To participate in decision-making with providers regarding their own health care, regardless of cost or benefit coverage, including the right to refuse treatment.
8. To voice grievances or appeals, either verbally or in writing, about the organization or the care they received.
9. To know the medical reason for the Alliance's decision to deny, delay, terminate, or change a request for medical care.
10. To get care coordination.
11. To ask for an appeal of decisions to deny, defer, or limit services or benefits.
12. To get no-cost interpreting services for their language.
13. To get legal help at their local legal aid office or other groups at no cost.
14. To formulate advance directives.
15. To ask for a State Hearing if a service or benefit is denied and they have already filed an appeal with the Alliance and are still not happy with the decision, or if they did not get a decision on their appeal after **30 days**, including information on the circumstances under which an expedited hearing is possible.
16. To disenroll from the Alliance and change to another health plan in the county upon request.
17. To access minor consent services.

18. To get no-cost written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
19. To request Confidential Communications. A member may choose an alternate address, phone, fax, or email to receive mailings from the Alliance.
20. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
21. To truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand, regardless of cost or coverage.
22. To have access to and get a copy of their medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
23. Freedom to exercise these rights without adversely affecting how they are treated by the Alliance, their providers, or the State.
24. To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside the Alliance's network pursuant to the federal law.
25. To access the Advice Nurse Line, anytime, 24 hours a day, 7 days a week. Medi-Cal members can call toll-free at **1.888.433.1876**. Group Care members can call toll-free at **1.855.383.7873**.
26. To access their medical records. They have the right to share the records of any telehealth services provided with their primary care doctor. These records will be shared with their primary care doctor unless they object.

## Alliance Member Responsibilities (G&A)

The Alliance is responsible for providing members with access to medically necessary covered services in a timely manner. Alliance members have certain responsibilities as well.

1. To treat all the Alliance staff and health care staff with respect and courtesy.
2. To give their doctors and the Alliance correct information (to the extent possible) needed to provide care.
3. To work with their doctor.
4. To learn about their health and help to set goals for their health.
5. To follow care plans and instructions for care that they have agreed to with their doctors.
6. To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
7. To always present their Alliance Member ID Card to receive services.
8. To ask questions about any medical condition, and make sure they understand their doctor's reasons and instructions.
9. To help the Alliance maintain accurate and current records by providing timely

information regarding changes in address, family status, and other health care coverage.
10. To make and keep medical appointments and inform their doctor at least **24 hours** in advance when they need to cancel an appointment.
11. To use the emergency room only in case of an emergency or as directed by their doctor.

## What Can You and Your Office Do to Protect Member Privacy? (Compliance)

- Keep PHI actively in mind and in your policies among your staff.
- Provide training for yourself and staff about privacy.
- Develop a process to respond to privacy issues that arise (including notifying the Alliance of any breach).
- Limit transporting PHI out of your office.
- Use secure email when communicating about members with someone outside your office.
- Store and lock up records and documents containing PHI.
- Secure your office computers from unauthorized access.
- Shred physical documents that contain PHI when no longer needed.
- Keep appointment and registration sheets away from public view.
- Do not text PHI.
- When speaking about, or to patients, in public areas use hushed tones so as not to be overheard by others

For more information about PHI and HIPAA compliance, please visit **www.hhs.gov**. If you have questions about how to improve the security and storage of member PHI or would like a copy of the privacy practices, please call the Alliance Provider Services Department at **1.510.747.4510**.

## How to Protect the Protected Health Information (PHI) of Your Patients (Compliance)

As you are well aware, protecting the privacy of patients and their Protected Health Information (PHI) is a responsibility that we all share. The Alliance is committed to protecting every member's PHI, and we want to ensure that you do too!

The Health Information Portability and Accountability Act (HIPAA) clearly outlines how providers can use and disclose PHI. Additional federal and California state laws have been enacted governing the release of information, mandating that information be protected, creating new breach notification rules, and setting civil and criminal penalties and fines for the inappropriate release of PHI.

Written patient permission is required for most uses and disclosures of PHI. The exceptions generally are that PHI may be used and disclosed for the purpose of

treatment, payment, and health care operations (and a few other specific exceptions).

# Section 26: Fraud, Waste, and Abuse (FWA) and Protected Health Information (PHI) (Compliance)

## Overview of Fraud, Waste, and Abuse (FWA) (Compliance)

The Alliance has developed an Anti-Fraud Program to comply with federal and state regulations in preventing and detecting fraud in federal, state, or county-funded programs offered by the Alliance. Health care fraud includes but is not limited to, the making of intentionally false statements, misrepresentations, or deliberate omissions of material facts from any record, bill, claim, or any other form for the purpose of obtaining payment, services, or any type of compensation for health care services for which members are not entitled.

The objective of the Alliance's Anti-Fraud Program is to identify and reduce costs caused by fraudulent activities and to protect members, health care providers, and others in the delivery of health care services.

The Alliance Compliance Officer and Compliance Committee oversees its Anti-Fraud Program and manages suspected fraud and abuse reporting. The Alliance reports its fraud/abuse prevention activities and suspected fraud/abuse to regulatory and law enforcement agencies as required by law.

## FWA Definitions (Compliance)

- Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.
- Waste: The overutilization or inappropriate utilization of services and misuse of resources.
- Abuse: Activities that are inconsistent with sound fiscal, business, or medical practices, and result in the following: unnecessary cost to health care programs or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary costs to health care programs.

## Examples of FWA (Compliance)

In general, fraud costs the state and federal taxpayers up to $260 billion annually.

Below are examples of fraudulent activity you may encounter as a health care provider in public programs.

***MEMBER/BENEFICIARY/RECIPIENT***

- Impersonation: Someone using the personal information of another person to obtain Medi-Cal or Medicare benefits for which he or she would otherwise not qualify or be entitled to receive.

***PROVIDER***

- Payment for referrals: When an individual or provider recruits and pays individuals money or offers gifts in exchange for referrals in the Medicare or Medi-Cal programs.
- Balance billing: A provider charging a Medicare or Medi-Cal beneficiary for the difference between the allowed reimbursement rate and the customary charge for the service.

***PROVIDER BILLING AND CODING ISSUES***

- Billing for services not rendered
- Billing for services at a frequency that indicates the provider is an outlier as compared with their peers
- Billing for non-covered services using an incorrect CPT, HCPCS, and/or diagnosis code in order to have services covered
- Billing for services that are actually performed by another provider
- Up-coding
- Unbundling services that should be billed together
- Billing for more units than rendered
- Services performed by an unlicensed provider yet billed under a licensed provider's name or information
- Altering records to receive covered services

## How to Report Potential FWA (Compliance)

The Alliance requires its providers, members, contractors, and subcontractors to report suspected fraudulent activity to the Alliance or the appropriate regulatory and law enforcement agencies.

Under no circumstances will the reporting of any such information or possible impropriety serve as a basis for retaliatory action to be taken against any individual making the report. No Alliance employee, provider, contractor, or member who reports suspected fraudulent activity will be retaliated against or otherwise disciplined by the Alliance or an Alliance employee for making a report in good faith.

When reporting FWA, please provide as much of the following information as possible:

- Name, address, license, or insurance ID of the suspect (if known).
- Description and details of the incident: who, what, where, when, date, and time of the incident(s).

- Any documentation you may have related to the incident(s).
- Your name and telephone number (if you would like to be contacted).

Any person may report a compliance or FWA matter through the following means:

Alliance Compliance Department:

Toll-Free Hotline: **1.844.587.0810**
Email: **compliance@alamedaalliance.org**

Medi-Cal Fraud and Abuse:
Toll-Free Hotline: **1.800.822.6222**
Email: **fraud@dhcs.ca.gov**

Medicare or Medi-Cal Fraud, Office of Inspector General:
Toll-Free: **1.800.447.8477**

The Alliance Compliance Line is available and can receive tips 24 hours a day, 7 days a week. The Hotline is operated by a third-party vendor to maintain confidentiality for the reporter.

## Health Insurance Portability and Accountability Act (HIPAA) (Compliance)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law that requires the Alliance and its network providers to protect and maintain the security and confidentiality of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights.

PHI is any individually identifiable health information, including demographic information. PHI includes but is not limited to the member's name, address, phone number, medical information, social security number, ID card number, date of birth, and other types of personal information.

This section of the Provider Manual seeks to guide providers on the following: 1) implementation of safeguards to protect Alliance member PHI; 2) ensure appropriate uses and disclosures of PHI; 3) ensure members are able to timely access their own PHI; and 4) how to identify and report privacy incidents and breaches to the Alliance.

## Safeguarding PHI (Compliance)

As covered entities under the HIPAA Privacy Rule, the Alliance, and its providers must comply with HIPAA requirements.

Below are a few reminders on how to protect and secure PHI.

***PHI IN PAPER FORM***

- Documents containing PHI should not be visible or accessible to visitors or others who are unauthorized to have access to PHI.
- When faxing documents containing PHI, verify the recipient, the recipient's fax number, and the documents being sent.
- Ensure that outgoing faxes include a fax cover sheet that contains a confidentiality statement.
- When mailing PHI, verify the recipient, the recipient's mailing address, and the documents being sent.
- Ensure that envelopes and packages are properly sealed, and secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope, prior to mailing out.
- When transporting PHI, ensure that the information is protected by using binders, folders, or protective covers.
- PHI must not be left unattended in vehicles.
- PHI must not be left unattended in baggage at any time during traveling.
- PHI should be locked away during non-business hours.
- PHI must be properly disposed of by shredding. Never recycle or dispose of documents containing PHI in the trash bin.

***PHI IN ELECTRONIC FORM***

- When transmitting PHI via email ensure that the email is encrypted. This prevents anyone other than the intended receiver from obtaining access to the PHI.
- Do not include PHI such as an individual's name or beneficiary ID number (CIN) in the subject line of the email.
- Confirm the recipient, recipient's email address, and documents or information being sent, prior to sending the email.
- Ensure all portable data storage devices (CDs, DVDs, USB drives, portable hard drives, laptops, etc.) are encrypted.

***PHI IN ORAL FORM***

- Do not discuss PHI in public areas such as the patient waiting room.
- Do not discuss PHI with unauthorized people.
- Always verify the identification of an individual prior to discussing PHI with the individual.
- Ensure to speak quietly when discussing PHI.

## Uses and Disclosures of Member PHI (Compliance)

The HIPAA Privacy Rule allows member PHI to be used and disclosed without the member's written consent for the following reasons (not a complete list):

- Treatment

- Payment
- Health care operations

And under certain circumstances PHI can be disclosed without written consent for the following reasons;

- Court and administrative proceedings
- Health oversight activities
- Public health activities
- Law enforcement purposes

Providers must obtain specific written consent through a HIPAA Compliant Authorization Form for all other uses and disclosures of PHI not for treatment, payment, or health care operations or otherwise permitted or required by the HIPAA Privacy Rule.

## Member Access to PHI (Compliance)

The HIPAA Privacy Rule requires the Alliance and its providers to provide members, upon request, with access to their PHI. Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever a member requests access to their PHI. Providers must also provide the member with timely access to their PHI in the form and format requested by the member.

## Reporting of Privacy Incidents and Breaches to the Alliance (Compliance)

The HIPAA Privacy Rule requires covered entities to provide notification to enrollees following a breach of PHI. Providers must immediately and upon discovery report both privacy incidents and breaches involving Alliance members. A privacy incident is defined as an event or situation where an individual or organization has suspicion or reason to believe that PHI may have been compromised.

Privacy incidents include but are not limited to the following:

- PHI sent to the wrong individual or organization.
- PHI sent unencrypted.
- Loss or theft of documents containing PHI.
- Loss or theft of unencrypted devices (laptop, hard drives, USB drives).

A breach is defined as unauthorized access, use, or disclosure of PHI that violates either federal or state laws, or PHI that is reasonably believed to have been acquired by an unauthorized person. Timely reporting of incidents and breaches involving the PHI of our members is crucial in the response, investigation, and mitigation of incidents and breaches.

To report suspected or known privacy incidents and breaches you may contact the Alliance through any of the following means:

Alliance Compliance Department
Toll-Free Hotline: **1.888.587.0810**
Email: deptCompliance**privacy@alamedaalliance.org**