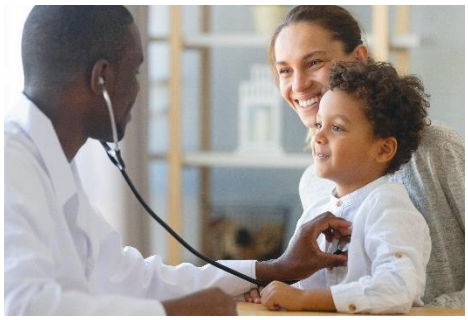
ALAMEDA ALLIANCE FOR HEALTH
SUMMARY OF KEY INFORMATION FOR PROVIDERS



Welcome to the Alliance provider network! This document provides key information about Alliance programs and requirements. More information is available in your Alliance contract, the Alliance Provider Manual, and on our website **www.alamedaalliance.org**.

The policies and procedures described herein are subject to change. For the most up-to-date information, please refer to the Alliance Provider Manual available online. You can also call the Alliance Provider Services Department at **1.510.747.4510**.

ALAMEDA Alliance FOR HEALTH

ALAMEDA Alliance FOR HEALTH

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Welcome to the Alliance Provider Network!

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

The Alliance is a local, public, not-for-profit, managed care health plan committed to making high-quality health care services accessible and affordable to Alameda County residents. For over 25 years, the Alliance has worked to provide programs and services you can trust and count on. The Alliance is honored to serve more than 280,000 children and adults throughout Alameda County.

Our Mission

We strive to improve the quality of life of our members and people throughout our diverse community by collaborating with our provider partners in delivering high-quality, accessible, and affordable health care services. As participants of the safety-net system, we recognize and seek to collaboratively address social determinants of health as we proudly serve Alameda County.

Our Vision

The Alliance will be the most valued and respected managed care health plan in Alameda County.

Our services are provided through two (2) lines of business:

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

If you have any questions about the Alliance, our practices, or our members, please call:

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

For more information about providers in our network, please view our online Alliance Provider Directory at **www.alamedaalliance.org/help/find-a-doctor**.

Our Plans

We are proud to offer **two (2)** comprehensive health plans for residents of Alameda County. By enrolling in the Alliance for Medi-Cal or Group Care, beneficiaries enjoy a large network of providers, assistance with care coordination, interpreter services, and a health plan that is local and responds to the needs of the community.

Medi-Cal

Medi-Cal is a state-sponsored health insurance program administered through the Alliance that offers comprehensive health care coverage at no monthly premium or copayment if income requirements are met. Some Medi-Cal beneficiaries are required by the State Medi-Cal program to be enrolled in a health plan and may be automatically enrolled in the Alliance. Medi-Cal Managed Care through the Alliance includes coverage for medical, mild-to-moderate behavioral health, and vision. Coverage for behavioral health/chemical dependency and dental services is provided by the State Medi-Cal fee-for-service (FFS) program. Eligibility for enrollment is determined by the State Medi-Cal program.

To apply for enrollment in the Medi-Cal program with the Alliance, beneficiaries can contact:

Health Care Options (HCO)
Toll-Free: **1.800.430.4263**
www.healthcareoptions.dhcs.ca.gov

They can also enroll by completing the Medi-Cal Choice Form that is available for download at **www.healthcareoptions.dhcs.ca.gov/download-forms**.

Alliance Group Care

Alliance Group Care provides coverage to In-Home Supportive Services (IHSS) who work in Alameda County. This plan includes coverage for medical, behavioral health/chemical dependency, and pharmacy services. Dental and vision coverage is provided to IHSS workers by the Public Authority (PA). Eligibility for enrollment is determined by the PA.

To apply for enrollment in the Alliance Group Care program, IHSS workers can contact:

Public Authority for IHSS in Alameda County
Main Phone Number: **1.510.577.3552**
Provider Health Benefits Phone Number: **1.510.577.3551**
www.ac-pa4ihss.org

Our Provider Network and Medical Groups

The Alliance network includes over 7,000 directly contracted providers including primary care providers (PCPs), specialists, and ancillary providers, including durable medical equipment providers, home health agencies, and physical/speech/occupational therapists. The Alliance is also contracted with most of the hospitals within Alameda County and three (3) medical groups (Children's First Medical Group (CFMG), Community Health Center Network (CHCN), and Kaiser Permanente). A list of the Alliance's network providers and hospitals can be found on the Alliance website. Each of the Alliance's three (3) medical groups also maintains a list of their providers on their websites.

Each medical group manages the authorizations, referrals, and claims of any Alliance member who chooses a PCP who belongs to that group – except for durable medical equipment (DME) authorizations.

PCP assignment determines the medical group to which an Alliance member is assigned. The medical group is responsible for managing the care of their assigned members, including utilization management and claims processing. Providers must follow the referral and authorization guidelines of the member's assigned medical group.

For more information, please refer to the **Referrals and Authorizations** section.

The Alliance supplies members with member ID cards that list their PCP/medical group assignment. It is, however, imperative to verify member eligibility before providing care. Eligibility and PCP/medical group assignment can change from month to month.

For more information, please refer to the **Eligibility** section.

If you receive a referral for an Alliance member assigned to **one (1)** of the Alliance's medical groups, please remember to:

1. Contact the member's assigned medical group before providing care to the member; or
2. Refer the member back to their PCP for a referral to a provider within the medical group.

Alliance Directly Contracted Providers

The Alliance is responsible for utilization management (authorizations) and claims processing for members who choose PCPs within the Alliance's direct network.

Children's First Medical Group (CFMG)

Children's First Medical Group (CFMG) is contracted with the Alliance to provide primary and specialty care to children **ages 0-20**. The CFMG network is composed of over 120 primary care providers and multiple ancillary and specialty care providers. CFMG is responsible for utilization management and claims processing for Alliance members who choose PCPs within the CFMG network.

Community Health Center Network (CHCN)

Community Health Center Network (CHCN) is contracted with the Alliance to provide primary and specialty care to Alliance members of all ages. The CHCN network includes over 400 primary providers and multiple ancillary and specialty care providers. CHCN is responsible for utilization management and claims processing for Alliance members who choose PCPs within the CHCN network.

Kaiser Permanente

Alliance Medi-Cal members assigned to Kaiser receive their primary, specialty, hospital, and vision from Kaiser Permanente.

Maintaining Your Alliance Contract

Demographic Changes

Please inform us promptly about changes to your practice, such as new hours of operation, a new address or suite number, phone, fax, tax identification number (TIN), ownership or group name change, provider additions or deletions, or any new practice limitations. A W-9 form is required for any changes to a group name, new ownership, or TIN.

Please notify us of the changes by completing the Provider Demographic Change Form. The form can be found in the quarterly provider packets. Forms are also available for download on the Alliance website at **www.alamedaalliance.org/providers/provider-forms**. You can submit the form via fax, mail, or email.

Please submit all changes to:

Alameda Alliance for Health
ATTN: Alliance Provider Services Department
1240 South Loop Road
Alameda, CA 94502
Fax: **1.877.747.4508**
Email: **providerservices@alamedaalliance.org**

Credentialing and Recredentialing

To participate in the Alliance provider network, PCPs, mid-level practitioners, and specialists are credentialed by the Alliance at the onset of their contractual relationship and again once every **three (3) years**. The Alliance Credentialing Department manages this process and notifies providers of the documents needed and the criteria that must be met. The Alliance's credentialing criteria comply with all applicable federal and state regulatory requirements.

Facility Site Review (FSR)

The Alliance is required by the California Department of Health Care Services (DHCS) to conduct facility site reviews (FSR).

Site reviews are conducted for primary care providers (PCPs) and obstetric/gynecological providers during the initial provider credentialing process. Additional PCP site reviews may be conducted every **three (3) years** as part of the ongoing recredentialing process.

The review includes a site review survey, a medical records review survey, and a physical accessibility review survey. The purpose of the review is to meet quality improvement standards and ensure compliance with regulations.

Contract Terminations

Providers must promptly notify the Alliance if they plan to terminate their relationship with the Alliance. It is especially important for a PCP to provide at least a **60-day** notice of termination to the Alliance. The Alliance is required by law to reassign patients to another PCP and to provide a **30-day** advance notification to members of this transition. Changes can be made in writing, and sent via fax, mail, or email.

Please submit all changes to:

Alameda Alliance for Health
ATTN: Alliance Provider Services Department
1240 South Loop Road
Alameda, CA 94502
Fax: **1.877.747.4508**
Email: **providerservices@alamedaalliance.org**

Quality Improvement (QI)

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® (Healthcare Effectiveness Data and Information Set) consists of performance measures used by most health plans that compare how a plan performs in quality, access to care, and member satisfaction. The California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) require that the Alliance participate in the annual HEDIS® process. HEDIS® measures are developed by a national group of health care experts. The measures are issued annually and used as a standard across the country. We want to ensure that we are offering quality preventive care and services to our members. HEDIS® allows us to monitor how we are performing compared to other health plans and identify areas of opportunity for improvement. The Alliance HEDIS® study methodology and results are also validated and audited by an external agency.

HEDIS® studies use claims and encounter data submitted by Alliance providers and may be supplemented with data retrieved from providers' medical records. The Alliance makes every effort to request records or schedule HEDIS® data retrieval once each year.

Potential Quality of Care and Service Issues (PQI)

The Alliance maintains a mechanism to identify, analyze, and resolve potential quality issues (PQIs) to ensure that services provided to members meet established quality of care and service standards. The Alliance Quality Improvement (QI) Department reviews and resolves PQIs in a timely manner and may request information from Alliance providers to assist with the review process.

PQIs can be identified in several ways, including:

1. Encounter data, including claims
2. Member or provider complaints

Member Eligibility

Determining Eligibility and PCP/Medical Group Assignment

Although Alliance members are issued identification (ID) cards, member eligibility and the benefits currently available to members should always be verified prior to providing care. Eligibility and PCP/Medical Group assignment can change from month to month. A referral or authorization does not guarantee that a member is eligible at the time of service.

It is important to note the medical group (CFMG, CHCN, Kaiser) to which a member is assigned because providers must follow the referral and authorization guidelines of the member's assigned medical group.

If you receive a referral for an Alliance member assigned to **one (1)** of the Alliance's medical groups, please remember to:

1. Contact the member's assigned medical group before providing care to the member; or
2. Refer the member back to their PCP for a referral to a provider within the medical group.

The Alliance provides **three (3)** easy ways to verify eligibility:

1. Visit our website and log on to the secure provider portal at **www.alamedaalliance.org**.
2. Call our Automated Eligibility Verification System at **1.510.747.4505**.
3. Call the Alliance Provider Services Department at **1.510.747.4510**.

Enrollment, Disenrollment, and PCP Changes

Alliance members can ask to change PCPs at any time.

Alliance members who wish to change their medical group and/or PCP or who wish to disenroll completely from the Alliance should be referred to:

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 PCP change effective date will be the first day of the following month. In some cases, a member may be added to a practice as long as the Alliance receives the assignment request before the fifth of the month. If you have questions about a member's eligibility or assignment, please contact the Alliance Provider Services Department.

Newborn Coverage

For Alliance Medi-Cal members, the Alliance covers newborns during the month of birth and the month following.

For Alliance Group Care members, the Alliance covers newborns for **30 days** following birth.

Access

Advice Nurse Line

Members can also contact the Advice Nurse Line any time, 24 hours a day, 7 days a week:

Members can call:

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

Key features of the Advice Nurse Line:

- No cost for Alliance Members.
- Ready to help 24 hours a day, 7 days a week.
- Nurses provide advice on topics, such as:
    - Treatment of common health concerns
    - Tips on leading a healthy lifestyle
    - Health screenings and shots
- Nurses help you decide whether you require emergency or urgent care, or if you should schedule a doctor's visit.

- Nurses speak English and Spanish and use interpreters for other languages.

After-Hours Access to Care

All PCPs are required to have after-hours phone coverage 24 hours a day, 7 days a week. After-hours access must include triage and screening (waiting time does not exceed 30 minutes) for emergency care and direction to call **911** for an emergency medical condition. A physician or mid- level provider must be available for contact after-hours, either in person or via telephone.

Emergency Services

Alliance members may seek care at any hospital emergency room (ER) within the United States for an emergency medical condition without authorization. ER services also include an evaluation to determine if a psychiatric emergency exists.

Any prudent layperson may determine if an ER visit is warranted. An emergency medical condition (including labor and delivery) is defined by Title 22, CCR, Section 51056, and Title 28, CCR, Section 1300.71.4.(b)(2) as one that is manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Death
- Placing the member's health in serious jeopardy
- Serious dysfunction of any bodily organ or part
- Serious impairment to bodily function

Interpreter and Translation Services

The Alliance provides no-cost telephonic and in-person interpreter services, including American Sign Language (ASL) for all Alliance-covered services 24 hours a day, 7 days a week. Professional interpreter services for medical encounters must be offered to Alliance members with limited English proficiency.

The Alliance provides interpreter services for appointments in non-hospital settings, as long as the provider is contracted with the Alliance. Hospitals are required to provide interpreter services to patients accessing care at their facilities.

In-person interpretation services can be arranged by contacting the Alliance at least **five (5) business days** in advance.

Telephonic Interpreter Services

Common uses for telephonic interpreter services:

- Routine office and clinic visits

- Pharmacy services
- Freestanding radiology, mammography, and lab services
- Allied health services such as physical, occupational, or respiratory therapy.

To access telephonic interpreters:

1. Please call **1.510.809.3986**; available 24 hours a day and 7 days a week.
2. Inform the operator you are an Alliance provider.
3. Provide the operator with the member's nine-digit Alliance ID number.
4. For communication with deaf, hearing-impaired, or speech-impaired patients, please call the California Relay Service (CRS) at **7-1-1.**

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 diagnosis (examples: cancer, chemotherapy, transplants, etc.)
- Sexual assault/abuse or other sensitive issues.
- End of life issues.
- Other conditions by exception. Please include your reason in the request.

To request in-person interpreters:

1. You must schedule in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
3. Please complete the Interpreter Services Appointment Request Form and fax it to the Alliance at **1.855.891.7172**. The form is available for download on the Alliance website at **www.alamedaalliance.org/providers/provider-resources/language-access**.
2. The Alliance will notify providers by fax if for any reason we *cannot* schedule an in-person interpreter.
3. 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**.

Please inform the operator you are an Alliance provider and provide the member's nine -digit Alliance ID number.

If a patient declines interpreter services, please document the refusal in the medical record.

This is required by the California Department of Health Care Services (DHCS) and the California Managed Risk Medical Insurance Board.

Prior Authorization (PA)

Authorization Process Overview

The Alliance Utilization Management (UM) Department works to ensure that medical services provided to our members are medically necessary, appropriate, and a part of the covered benefits.

The Alliance UM Department is managed by our Health Care Services Department.

The Alliance UM team is made up of authorization specialists, pharmacists, nurses, and physicians. The Alliance follows nationally recognized evidence-based criteria and considers individual member circumstances when making medical service decisions.

For the most up-to-date information, or if you have questions, please call:

Alliance Utilization Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4540**

To submit an authorization request, please log on to our provider portal to submit an electronic request or complete the Alliance Prior Authorization (PA) Request Form and submit by fax to the Alliance UM Department at **1.855.891.7174**. The form is available for download at **www.alamedaalliance.org/providers/provider-forms**. This fax number can be used to send authorization and utilization inquiries and requests to the Alliance UM Department during and outside of business hours. In both cases, supporting clinical documentation is required.

The authorization process described in this section applies to members assigned to PCPs who are contracted directly with the Alliance or for members who have not yet been assigned to a PCP. Authorization and referral requirements may be different for members assigned to one of the Alliance's medical groups (CFMG, CHCN, Kaiser). Please contact the member's assigned medical group to find out if authorization is required for a particular service.

Services that Require Prior Authorization (PA) from the Alliance

The following services require prior authorization (PA) from the Alliance:

1. Cancer Clinical Trials
2. Cataract Spectacles and Lenses
3. Chiropractic Services – Line of Business Limits May Apply
4. Durable Medical Equipment (DME) and Supplies
5. Elective Inpatient Admissions

6. Enteral or Nutritional Formulas
7. EPSDT Supplemental Services
8. Hearing Aids and Repairs
9. Home Health Care or Home Infusion Services
10. Hospice Services – Inpatient Services
11. In-Office Injectable and Oncology Drugs (specific drugs)
12. Non-emergent Medical Transportation
13. Nutrition or Dietician Assessment/Counseling (except Sweet Success)
14. Organ Transplants
15. Orthotics and Prosthetics
16. Out-of-Network Services
17. Perinatologist's Care of Pregnancy (excludes consultation)
18. Physical, Occupational, Speech, and Respiratory Therapy
19. Podiatry care for Alliance Medi-Cal members (excludes consultation)
20. Radiology (such as MRI, PET, and Nuclear Medicine)
21. Second Opinions (if the provider is not contracted with the Alliance)

PA requests should be accompanied by medical records to assist the Alliance's clinical reviewers with determining whether the requests meet the Alliance's criteria for coverage.

Prior Authorization (PA) Exceptions

The following services **do not** require prior authorization (PA):

1. Emergency care within the United States.
2. Obstetrical and gynecological services, including basic prenatal care and support services
3. available through the member's medical group.
4. Preventive care in the Alliance network.
5. Sensitive services.
6. Standing referrals to specialty care in the Alliance network.

Inpatient Admission Notification Process*

Emergency inpatient admissions do not require PA. However, hospitals must notify the Alliance Utilization Management (UM) Department of an emergency inpatient admission within **one (1) working day**.

The Alliance UM Department clinical staff is responsible for concurrent review of hospital stays and for assisting with discharge planning. Hospitals and treating providers are reimbursed by the Alliance as long as timely notification of an admission has been received.

*Hospitals must notify the appropriate Alliance medical group of admissions for their members.

Contacts for Authorization

All requests for authorization must be sent to the Alliance or the member's medical group.

Health Plan/ Medical Group	Address	Authorization Department Numbers	Alliance Programs
Alliance	1240 South Loop Road Alameda, CA 94502 **www.alamedaalliance.org**	Phone Number: **1.510.747.4540** Fax: **1.855.891.7174** Main Number: **1.510.747.4500**	Medi-Cal, Group Care
Children First Medical Group (CFMG)	6425 Christie Ave #110 Emeryville, CA 94608 **www.childrenfirstmedicalgroup.org**	Phone Number: **1.510.428.3489** Fax: **1.510.428.5868** Main Number: **1.510.428.3154**	Medi-Cal
Community Health Center Network (CHCN)	101 Callan Ave, 3rd Floor San Leandro, CA 94577 **www.chcnetwork.org**	Phone Number: **1.510.297.0220** Fax: **1.510.297.0222** Main Number: **1.510.297.0200**	Medi-Cal, Group Care
Kaiser	**www.kaiserpermanente.org**	Main Number: **1.800.464.4000**	Medi-Cal

Timeframes for Authorization Processing

The Alliance will make a determination status via letter or verbal notification within the following timeframes:

Request Type	Authorization Processing Timeframes for Medi-Cal and Group Care
Inpatient Hospice Care	Within **24 hours** of receipt.
Medically Urgent Requests	Within **72 hours** of receipt.
Non-Urgent Requests	Within **five (5) business** days of receipt.
Routine Pre-Authorization	Within **5 business days** of receipt.
Post-Service Decisions	Considered if submitted within **30 days** of date of service.
Urgent Concurrent Decisions	Within **24 hours** of notification, if clinical is available; **72 hours** if clinical is requested.

Retrospective/Post-Service Process

Post-service/retrospective review is the process in which utilization review is used to determine medical necessity or coverage under the health plan benefit. Post-service/retrospective authorizations are only considered if submitted within **30 days** of the date of service.

To contact the Alliance UM Department, please call:

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**.

Requests are reviewed based on Alliance policies and established practices for medical necessity. The Alliance does not accept non-emergency or non-urgent services that require prior authorization after the date of service.

The following retrospective request exceptions will be considered:

- Post-stabilization.
- Provision of inpatient services where the facility is unable to confirm enrollment with the Alliance.
- Requests due to member eligibility issues.

Post-service requests submitted within **30 calendar days** of the date of service, and when a claim is not on file, will be reviewed by the Alliance UM Department. Turnaround times for review will follow state regulatory guidelines.

PLEASE NOTE: Retrospective/post-service requests are not urgent and will not be processed as such. Post-service requests submitted after **30 calendar days** from the date of service should be submitted with your claim and will be processed via the Retro Claims Submission Review process. Requests for services that do not meet the criteria above are subject to denial as no authorization has been obtained.

Referrals

Services that Require a PCP Referral

Services	Documentation Requirements

• Diagnostic imaging studies at any facility contracted with the Alliance (authorization required for certain diagnostic codes).
• Outpatient elective surgery at any facility contracted with the Alliance (authorization required for certain CPT codes).
• Specialty care referrals to Alliance-contracted specialists, including consultations and in-office procedures.
• Sweet Success services for prenatal diabetic care.
	• PCPs may refer the member to specialty care in writing or by phone.
	• Once the initial referral is made additional referrals to the same specialist are not required for care related to that condition.
	• The specialist is required to:
	  ○ Verify the member's eligibility at the time of service.
	  ○ Verify the referral from the PCP.
	  ○ Provide feedback to the PCP.
	  ○ Document the referring PCP's name in Box 17 of the CMS 1500 or Box 82 of the UB-92 for **ALL** consults and procedures related to the referred condition.
	PLEASE NOTE: Claims that do not contain this information will be denied.

Direct Access to OB/GYNs

Alliance members may self-refer for covered obstetrical and gynecological services from OB/GYNs participating within the Alliance or their medical group's network.

Sensitive Services

Sensitive services are designated by the State Medi-Cal program and are made available to members without a referral or authorization to protect patient confidentiality and promote timely access. Sensitive services include family planning, screening and treatment for sexually transmitted diseases, HIV testing, and abortions.

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.

Group Care members are encouraged to use family planning, HIV testing, and sexually transmitted disease services provided by the Alliance or their medical group. Referral or authorization may be required to access these services outside of the network.

Sterilization Services

California law (Title 22, Sections 51305.1 and 51305.4) requires that Medi-Cal beneficiaries who request sterilization (surgery that will end their ability to have children) complete a form (PM-

330) attesting that they are giving informed consent for the procedure. These forms must be completed and signed **30 days** prior to the surgery and filed in their medical record. Medi-Cal members may not waive the 30-day waiting period. A copy of the form must be attached to the primary surgeon's claim when submitted for payment. A copy of the form can be found on the Medi-Cal website at **https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf**.

Abortion

In-network abortion services are available to all Alliance members without referral or authorization.

Alliance Medi-Cal members may obtain abortion services from any Medi-Cal provider without a referral or authorization.

Group Care members are encouraged to use abortion services provided within the Alliance's or their medical group's network before seeking authorization to be seen by an out-of-network provider.

Minor Consent Services

California law (California Family Code, Sections 6920 – 6929) gives minors the right to access some services without parental consent. Medical records and/or information regarding medical treatment specific to these services cannot be released to parents and guardians without the minor's consent.

Minors of any age may consent to and receive:

- Family planning services and medical care related to the care or prevention of pregnancy, except sterilization.
- Abortions performed under emergent medical conditions.
- Medical care after a sexual assault.
- Minors **12 years of age and older** may consent to and receive:
    - Diagnosis and treatment of sexually transmitted diseases.
    - Outpatient mental health care services, including drug and alcohol abuse treatment.

Benefits

Medical Benefits

For Alliance Medi-Cal and Group Care members, the Alliance covers medical services that are medically necessary and covered by the Medi-Cal program at the time of service. Benefits include primary care, specialty care, durable medical equipment (DME), home health, inpatient care, and skilled nursing care. A complete list of covered services can be found in the Alliance Provider Manual at **www.alamedaalliance.org/providers/alliance-provider-manual**.

Unless specifically indicated, the Alliance does not cover services that are not covered by Medi-Cal, including cosmetic services, infertility treatment, and experimental and investigational procedures.

Podiatry Services

The Alliance covers podiatry services in accordance with the State Medi-Cal program. Podiatric office visits are covered as medically necessary. Services are limited to diagnosis, medical, surgical, mechanical, and electrical treatment of the foot, ankle, and muscles related to functions of the foot.

Alliance members may access this benefit initially by obtaining a referral from their PCP. All additional services will require prior authorization (PA) submitted by the podiatrist.

For members assigned to one of the Alliance's medical groups, a PA may be required. Please contact the assigned medical group for additional information.

Pharmacy Benefit – Outpatient Pharmacy Services (Group Care)

Alliance pharmacy benefits are administered by PerformRx, the Alliance's Pharmacy Benefit Manager. PerformRx is responsible for pharmacy claims processing, pharmacy contracting and oversight, processing drug authorization requests in a timely manner, and formulary management.

PerformRx also processes prior authorization (PA) requests for specialty drugs dispensed by Diplomat Specialty Pharmacy (Diplomat). Diplomat is the only pharmacy that can dispense certain specialty drugs for Alliance Medi-Cal and Group Care members.

A complete description of the Alliance's specialty pharmacy program and drugs covered under the program can be found at **www.alamedaalliance.org**.

Providers can reduce the need for PA requests for non-formulary drugs by prescribing drugs from the Alliance formulary. For Medi-Cal and Group Care, a Prescription Drug Prior Authorization (PA) Request Form must be sent to PerformRx via their confidential fax at **1.855.811.9329**.

The form is available for download at **www.alamedaalliance.org/providers/pharmacy-formulary/prescriptiondrug-prior-authorization-pa-requests**.

For more information, please call:

PerformRx
Monday – Friday, 8 am – 6 pm
Toll-Free: **1.855.508.1713**

Pharmacy Benefit – Outpatient Pharmacy Services (Medi-Cal)

For Medi-Cal, outpatient pharmacy the benefit if administered by the Department of Health Care Services (DHCS) through their PBM, Magellan Medicaid Administration, Inc. (Magellan) as of January 1, 2021. This is collectively known as "Medi-Cal Rx". The Alliance is not the administrator for the Medi-Cal pharmacy benefit. Individual prescribers will each need to register to the Medi-Cal Rx portal to be a user. Pharmacy Service Representatives (PSRs) and YouTube tutorials are available for walkthrough registration.

For questions related to provider registration for Medi-Cal Rx, please visit the Medi-Cal Rx website or email:

Website: **medi-calrx.dhcs.ca.gov/provider**
Email: **medicalrxeducationoutreach@magellanhealth.com**

For more detailed information about covered products please refer to the Medi-Cal Rx Contract Drugs List (CDL) and Provider Manual.

Provider Manual: **medi-calrx.dhcs.ca.gov/home/provider-manual**
Medi-Cal Rx Drug List: CDL: **medi-calrx.dhcs.ca.gov/home/cdl**

There are five (5) ways to submit a request for authorization to Medi-Cal Rx:

1. Medi-Cal Rx Secure Portal: The prior authorization system information and forms will be available on the Medical-Cal Rx site at **www.medi-calrx.dhcs.ca.gov**.
2. CoverMyMeds: Providers can create an account and log in to submit a PA on the CoverMyMeds website at **www.covermymeds.com**
3. NCPDP P4
4. Fax: **1.800.869.4325** (starting Saturday, January 1, 2022)
5. Mail

   Medi-Cal Rx Customer Service Center
   Attn: PA Request
   P.O. Box Number 730
   Rancho Cordova, CA 95741-0730

For questions related to outpatient pharmacy services for Medi-Cal, please call:

Magellan at the Medi-Cal Rx Call Center
Toll-Free: **1.800.977.2273**
TDD: **711**
www.medi-calrx.dhcs.ca.gov

Behavioral Health Services

All Alliance members have access to outpatient and inpatient behavioral health care services, which includes substance abuse treatment. PCPs and specialists can encourage any member who appears to be in need of behavioral health care to access this confidential benefit at no cost.

For Alliance Medi-Cal members, behavioral health services (moderate to high severity) are provided by Alameda County Behavioral Health Care Services (BHCS). Members can self-refer for most behavioral health services and can contact BHCS toll-free at **1.800.491.9099**.

For all Alliance members, behavioral health care services (mild to moderate, and autism services) are provided by Beacon Health Options (Beacon). Prior authorization (PA) is not required for routine outpatient behavioral health care services. Members can self-refer for most services.

For more information or to self-refer, members can call:

Beacon Health Options
Toll-Free: **1.855.856.0577**
www.beaconhealthoptions.com

Laboratory Services

The Alliance contracts with Quest Diagnostics (Quest) to provide most outpatient laboratory services.

Providers must use Quest for most laboratory services, including specimen reading, except for:

1. Genetic, chromosomal, and alpha-fetal protein prenatal testing that is not available at Quest
2. HIV testing
3. Renal tests performed at a dialysis center
4. Lab services performed at **one (1)** of the following Alliance-contracted hospitals:
    - Alameda Health System (AHS)
    - Alta Bates Summit Medical Center
    - UCSF Benioff Children's Hospital Oakland

Alliance members assigned to any of the AHS campuses, Highland Hospital, Fairmont Rehab and Wellness, Hayward Wellness, Newark Wellness, etc., will use the AHS campus for any lab request from their provider.

To find a Quest lab, providers can call:

Quest Client Services
Toll-Free: **1.800.288.8008**

For courier services, STAT pick up, or will call, providers can call:

Quest Diagnostics
Toll-Free: **1.800.288.8008, option 3**

Dental Services

For Alliance Medi-Cal members, dental services are provided by Denti-Cal. A dental screening by the PCP is part of the Initial Health Assessment (IHA) and California Child Health & Disability Prevention (CHDP) Program checkups. PCPs should encourage adult Medi-Cal members to seek dental care from low-cost dental providers.

Members can self-refer for dental services and assistance by calling:

Denti-Cal
Toll-Free: **1.800.322.6384**

For Alliance Group Care members, the IHSS Public Authority contracts with Delta Dental to provide dental care. Group Care members can contact the IHSS PA if they have questions regarding their dental coverage or need to enroll in the dental plan.

To find a participating dental provider, Alliance Group Care members can call:

Delta Dental
Toll-Free: **1.888.335.8227**

Vision Benefits

For Alliance Medi-Cal members, vision services are provided by MARCH Vision Care.

The Alliance covers:

- Routine eye exam once every **24 months**; the Alliance may pre-approve (prior authorization) additional services as medically necessary.
- Eyeglasses (frames and lens) once every **24 months**; contact lens when required for medical conditions such as aphakia, aniridia, and keratoconus.

Alliance Medi-Cal members may self-refer to MARCH providers, or a PCP can refer a member to a participating MARCH provider.

For questions regarding vision benefits or to find a MARCH provider, please contact:

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

For Alliance Group Care members, the IHSS Public Authority contracts with EyeMed Vision Care to provide eye care. Group Care members can contact the IHSS PA if they have questions regarding their vision coverage.

To find a participating eye care provider, Alliance Group Care members can call:

EyeMed Vision Care
Toll-Free: **1.866.723.0514**

PLEASE NOTE: Ophthalmology care is a medical benefit through the Alliance and there is no age restriction for these services for any of our plans. PCP referral is required, and the care must be provided by contracted ophthalmologists.

Chiropractic and Acupuncture Benefits

For Alliance Medi-Cal members, chiropractic services are limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to **two (2)** services per month in combination with acupuncture, audiology, occupational therapy, and speech therapy services. The Alliance may pre-approve other services as medically necessary.

The following members are eligible for chiropractic services:

- Children under 21 years of age;
- Pregnant women through the end of the month that includes **60 days** following the end of a pregnancy;
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility; or
- All members when services are provided at hospital outpatient departments, FQHC, or RHC.

For Alliance Medi-Cal members, The Alliance covers acupuncture services to prevent, modify, or alleviate the perception of severe, persistent, chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of needles) are limited to **two (2)** services per month, in combination with audiology, chiropractic, occupational therapy, and speech therapy services. The Alliance may pre-approve (prior authorization) additional services as medically necessary.

For Alliance Group Care members, the Alliance covers chiropractic care as long as all services are obtained from participating Alliance chiropractors. The benefit is limited to **20** visits per benefit year (October 1 – September 30).

For Alliance Group Care members, the Alliance covers acupuncture treatment as long as all services are obtained from participating Alliance acupuncturists. The benefit is limited to **10** visits per benefit year (October 1 – September 30).

Transplants

Effective January 1, 2022, the Alliance is responsible for all Major Organ Transplants (MOT) including Bone Marrow Transplant (BMT) for Alliance Medi-Cal members. Previously, the Alliance covered kidney and corneal transplants and all other organ transplants were provided through the State fee-for-service (FFS) Medi-Cal program. The Alliance is contracted with Stanford and UCSF Medical Center for a transplant network.

For Alliance Group Care members, the Alliance covers medically necessary organ and bone marrow transplants.

Custodial Care

Custodial care is not covered by the Alliance for any of the Alliance's plans. The State fee-for-service (FFS) Medi-Cal program may cover custodial care for Alliance Medi-Cal members if they request and are granted enrollment back into FFS Medi-Cal.

Health Education

The Alliance offers health education materials, classes, and programs to all Alliance members. For more information, please visit the Patient Health & Wellness Education section on the Alliance website at **www.alamedaalliance.org/providers/patient-health-wellness-education**.

Transportation Benefit

For Alliance Medi-Cal members, transportation services are offered through the Alliance's transportation provider, LogistiCare. There is no cost when transportation is authorized by the Alliance.

The Alliance offers non-emergency medical transportation (NEMT) and non-medical transportation (NMT) services. A provider or member can request transportation by calling LogistiCare toll-free at **1.888.457.3352**.

Case and Disease Management (CMDM) Program

PCPs are delegated the responsibility to provide basic comprehensive medical case management services to their assigned Alliance members. The Alliance has a high-risk Case and Disease Management (CMDM) program available for our Medi-Cal and Group Care members. The program's objectives include providing an ongoing patient and family assessment and treatment plan to maximize quality of care while minimizing costs and providing support to both the member and the provider.

The CMDM program is designed to assist in managing the care of medically complex members by coordinating services that will ensure the improvement of patient outcomes and overall member satisfaction.

How to Enroll

- You can refer your patients by completing the Alliance Case Management Programs Referral Form found at **www.alamedaalliance.org**.
- The Alliance may also contact the member to see if they would like to enroll.
- Members may also self-refer.

  You can advise your patient 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**

Enhanced Care Management (ECM) Program

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, 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.

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

There is no cost to the member for ECM services. Members can be referred for ECM by their provider to:

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**

Community Supports (CS) Program

Community Supports (CS) services may be available for Alliance members under their Individualized Care Plan. 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 may help them live more independently but do not replace benefits that they already get under Medi-Cal.

CS Services Offered by the Alliance

The Alliance is currently offering the following CS services:

- Homeless-related CS (Includes housing transition navigation, housing deposits, and housing tenancy & sustaining services);
- Recuperative Care (Medical Respite)
- Medically Tailored/Supportive Meals; and
- Asthma Remediation.

There is no cost to the member for CS services. Members can be referred for CS by their provider to:

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**

Health Assessments

Initial Health Assessment (IHA)

PCPs must provide each new Alliance members with an Initial Health Assessment (IHA) as soon as possible after enrolling with the Alliance. The State Medi-Cal program mandates that all new Medi-Cal members have an IHA within **120 days** from the member's enrollment date with the plan.

Pregnant women must have their IHA as soon as an appointment can be scheduled. The IHA should follow appropriate preventive health guidelines and should include a physical examination with referrals for lab work and tests as indicated, immunizations, and a nutritional assessment.

Staying Healthy Assessment (SHA)

PCPs should ask each Medi-Cal member to complete the Staying Healthy Assessment (SHA). The SHA is an age-specific risk assessment tool that is repeated at specific age intervals. PCPs use the SHA to assess, counsel, and refer members regarding many issues, including nutrition, home safety, smoking, drug and alcohol use, and exposure to violence.

The Alliance covers additional screening, counseling and referrals, alcohol misuse screening and counseling (AMSC), and tobacco cessation. Benefits, forms, training, and instructions for SHA and AMSC can be found at **www.alamedaalliance.org**.

Child Health and Disability Program (CHDP) Reporting

The Child Health and Disability Program (CHDP) oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal members **younger than 21 years of age**. CHDP is responsible for ensuring that high-quality preventive services are delivered and available to eligible children and youth.

Coordination of Care

California Children's Services (CCS)

California Children's Services (CCS) provides medical care for children **younger than 21 years of age** who have physical disabilities and complex medical conditions. Services provided under the CCS program are reimbursed through the CCS program. The Alliance is not financially responsible for CCS services provided to Alliance members. An Alliance member who is eligible for CCS services remains enrolled with the Alliance. The PCP, the Alliance, and medical group staff are responsible for identification, referral, and case management of members with CCS-eligible conditions. Until eligibility is established with the CCS program, the PCP, the Alliance, and medical group continue to provide medically necessary covered services related to the CCS -eligible condition. Eligible conditions include medical conditions such as sickle cell anemia, cancer, diabetes, HIV, and major complications of prematurity.

Providers can refer patients by contacting:

California Children's Services (CCS)
1000 Broadway, Suite 500
Oakland, CA 94607
Phone Number: **1.510.208.5970**
Fax: **1.510.267.3254**
www.dhcs.ca.gov/services/ccs

Regional Center of the East Bay (RCEB)

Regional Center of the East Bay (RCEB) is a private, nonprofit agency established to assist adults and children who have developmental disabilities, and individuals who are substantially handicapped by cerebral palsy, epilepsy or autism, and their families in locating services in their communities.

To be eligible, a member must meet the following criteria:

- Disability began prior to **18 years of age**.
- Disability is due to mental retardation, cerebral palsy, epilepsy, autism, or a condition similar to mental retardation.
- Disability is likely to continue indefinitely and is substantially handicapping for the individual.
- RCEB provides members with the services they need to function independently. Main areas of assistance include:
    - Durable medical equipment
    - Help finding housing

- Providing respite services, including childcare
- School or adult day programs and social activities
- Speech or physical therapy (PT)/occupational therapy (OT) services
- Transportation

The Alliance is not financially responsible for RCEB services provided to Alliance members. An Alliance member who is eligible for RCEB services remains enrolled with the Alliance. The PCP, the Alliance, and the medical group are responsible for coordination of services and for continued medical care.

Providers can refer patients by contacting:

Regional Center of the East Bay (RCEB)
76777 Oakport Street, Suite 300
Oakland, CA 94621
Phone Number: **1.510.618.6100**
www.rceb.org

Early Start Program

The Early Start Program is available through the Regional Center of the East Bay. Early Start is for infants and toddlers from **birth to three (3) years of age** who have problems that may result in developmental delays, or who show signs of developmental delays.

The Early Start Program serves infants and toddlers **three (3) years of age or younger** who have:

- A combination of biological and/or psychosocial factors that indicate a high risk for developmental disabilities.
- A diagnosed developmental disability that is expected to continue indefinitely.
- Significant developmental delays in cognitive, physical (motor, vision, and hearing), communication, social/emotional, and adaptive/self-help functions.

The Early Start Program provides a wide range of services, including speech and hearing evaluations and treatment. The Alliance is not financially responsible for the Early Start services provided to its members. The member's PCP is responsible for providing the initial evaluation and treatment. An Alliance member who is eligible for Early Start services remains enrolled with the Alliance. The PCP, the Alliance, and the medical group remain responsible for coordination of services and for continued medical care.

Providers can refer patients by contacting:

The Early Start Program
1600 9th Street
Sacramento CA, 95814
Phone Number: **1.800.515.BABY** (**1.800.515.2229**)
Email: **earlystart@dds.ca.gov**
www.dds.ca.gov/services/early-start

Women, Infants & Children Program (WIC)

The Women, Infants & Children (WIC) nutrition/food program helps pregnant, breastfeeding, or postpartum women, and children **less than five (5) years of age** eat well and stay healthy. WIC eligibility is determined by federal income guidelines. Services include free food vouchers, nutrition education, and breastfeeding support. To find a local WIC office or receive assistance with applying for this service, Alliance members can call WIC at **1.916.572.0700** or visit **www.calwic.org**.

Claims

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

For questions regarding claims submissions, please call:

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

Claim Requirements

The Alliance has established requirements for filing a claim. Failure to comply with these requirements may jeopardize reimbursement.

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

- Be submitted on a standard current version of a CMS-1500, CMS-1450 (UB04), or the ANSI X12-837-4010A1 (current electronic format)
- Contain appropriate information in all required fields
- Be a claim for an Alliance member eligible at the time of service
- Be an original bill

- Contain correct national standard coding, including but not limited to CPT, HCPCS, Revenue, and ICD-9 codes
- Not be altered by handwritten additions to procedure codes and/or charges
- Be signed, if paper
- Be printed with ink that is dark enough to be electronically imaged, if paper
- Be received within the filing period

Electronic Data Interchange (EDI) Services

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

Providers interested in submitting claims electronically can contact:

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

Where to Send Your Claims

If sending claims by US Postal Service (USPS), professional claims for all Alliance members should be submitted for processing as follows:

Member's Health Plan/ Medical Group	Claim Type(s)	Mailing Address
Alameda Alliance for Health	• Professional medical service • All hospital/facility claims	Alameda Alliance for Health P.O. Box 2460 Alameda, CA 94501-0460
Children's First Medical Group (CFMG)	• Professional medical service	Children's First Medical Group P.O. Box 99680 Emeryville, CA 94662-9680
Community Health Center Network (CHCN)	• Professional medical service	Community Health Center Network 101 Callan Ave, Suite 300 San Leandro, CA 94577
Alliance Medi-Cal Members	• Mild to moderate behavioral health services	Beacon Health Options P.O. Box 1862 Hicksville, NY 11802-1862

Member's Health Plan/ Medical Group	Claim Type(s)	Mailing Address
Alliance Medi-Cal Members	• Specialty mental health services • Mental health facility claims	Alameda County Behavioral Health Care Services Claims Processing Department P.O. Box 738 San Leandro, CA 94577
Alliance Group Care members	• Mental health claims	Beacon Health Options P.O. Box 1862 Hicksville, NY 11802-1862

Timely Filing Timeframes

All claims must be submitted in a timely manner 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.

When the Alliance Is the Primary Payer on the Claim: Participating (contracted) providers must submit claims **180 calendar days** post-service. 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.

When the Alliance Is Not the Primary Payer under Coordination of Benefits (COB): Providers must submit a claim to the Alliance within **90 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, indicating 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: Providers are required to submit a claim to the Alliance within 60 days of receiving the correct insurance information from the member or incorrect payer. Providers must also submit proof that the member or another payer had been billed.

Corrected Claim Previously Denied by the Alliance as an Incomplete Claim: The claim must be submitted correctly for reconsideration of payment within **90 days** of 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.

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 insurance carrier

- Copy of enrollment card presented at time of service

General Claims Processing Guidelines

Acknowledgement of Claim Receipt: The Alliance will identify and acknowledge the receipt of a claim within **two (2) working days** of receipt if the claim was received electronically or within **15 working days** if a paper claim was received.

Billing Members: Providers are prohibited from billing Alliance members for covered services. Under the California Health and Safety Code, Section 1379, it is illegal to bill a member who is enrolled in a State program for services provided.

Alliance members are never responsible for paying participating providers any amount for covered medical services, other than approved co-insurance, deductibles, or copayment amounts as 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. Providers may only bill members for copayments, non-benefits, and for non-covered services.

Claim Processing Time: The Alliance will process and pay all clean claims within **45 business days** of receipt.

Clean Claim: A clean claim is defined as a claim which, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability, and make timely payment.

Coordination of Benefits (COB): Coordination of Benefits for claims that are not related to the Coordination of Benefits Act (COBA) (listed below) is used to determine the order of payment responsibility when an Alliance member is covered by more than one health plan or insurer. The Alliance is always the payer of last resort for Medi-Cal members; all other coverages are primary. State and federal laws require practitioners to bill other health insurers prior to billing the Alliance.

All claims must be submitted to the Alliance within **90 days** from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB must accompany the claim. If the primary plan denies services asking for additional information, that information must be submitted to that carrier prior to submitting the claim to the Alliance.

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.
- 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.

Coordination of Benefits Act (COBA): Effective Friday, October 30, 2020, the Alliance will begin to receive crossover claims directly from Medicare for members who have Medicare as their primary coverage for the following claim types and will automatically process the following secondary claim types:

- Durable Medical Equipment (DME)
- Inpatient Hospital – Type of Bill 11x and 12x
- Outpatient Home Health – Type of Bill 34x
- Outpatient Hospital – Type of Bill 13x and 14x
- Skilled Nursing Facility – Type of Bill 21x, 22x, and 23x

The Explanation of Medicare Benefits (EOMB) from their Medicare claim will inform providers that the claim has been forwarded to the Alliance. This will indicate that providers will no longer need to submit a hard copy of the (paper) original claim with the EOMB.

The following other claim types are still required to be submitted via paper form with the EOMB until further notice:

- All Type of Bill claims not listed above
- Corrected/adjusted claims
- Professional claims
- DME claims that require an invoice

When a claim(s) is received from Medicare, the Alliance will coordinate benefits with Medicare's payment to determine whether any additional amount is due from the Alliance. If the amount Medicare paid is more than the Alliance's allowed amount, no additional payment will be made. Claims received directly from Medicare will be processed within **45 working days** upon receipt from Medicare. If we receive a COBA claim that is not one of the claim types listed above, the provider will be sent a notice with further information and instructions.

For additional details about billing and claim submission, please visit the Alliance website at **www.alamedaalliance.org/providers/billing.**

Interest on Claims: The Alliance will calculate and automatically pay interest, in accordance with AB1455 requirements, to all providers of service who have not been reimbursed for payment within **45 business days** after the receipt of their clean claim.

Misdirected Claims: When a claim is incorrectly sent to the Alliance that should have been sent to one of its delegated partners (i.e., CHCN, Beacon, etc.), the Alliance forwards the claim to the appropriate delegated partner within **10 working days** of receipt of the claim. The Alliance also sends a notice of denial to the provider with instructions to bill the delegated partner.

Overpayments and Recoupments: Overpayments can happen for several reasons, including, but not limited to:

- Alliance claim processing error
- Another party paid for the service (i.e., COB)
- Duplicate payment made by the Alliance when service is payable, in part or full, to another provider
- Retroactive change to member eligibility

The Alliance Claims Department makes recoupment requests in writing within **365 days** of the date the original claim was paid. A provider may either contest the request for recoupment or pay the requested monies within **30 working days** of receipt of the notification of overpayment or adjustment by the Alliance. If the provider does not contest or repay the requested monies within **30 working days**, the Alliance may offset the requested amount against future claim payments.

Procedure and Diagnosis Codes: Providers must use procedure and diagnosis codes that are covered by Medi-Cal and that adhere to national correct coding standards to bill for services for Alliance Medi-Cal, Group Care, and Healthy Families members.

Service-Specific Claims Processing Guidelines

Ambulance, Emergency, Urgently Needed, and Post-Stabilization Care Services: The Alliance is financially responsible for ambulance, emergency, urgently needed, and post-stabilization care services, whether services are obtained in or out of network. The Alliance makes prompt determination and reasonable payment to or on behalf of the members for these services when the financial responsibility is that of the Alliance.

Family Planning Services and STD Services: PCPs and specialists providing family planning and STD services may be reimbursed fee-for-service (FFS) except when the services are provided by PCPs to their capitated members. PCPs rendering these services to their assigned members may be reimbursed FFS for those procedures not included in the capitation, though all services should be documented on the claim form.

HIV Testing and Counseling: The Alliance pays providers fee-for-service (FFS) for HIV testing and counseling except when the services are provided by a PCP to their capitated members. PCPs rendering these services to their capitated members may be reimbursed fee-for-service for those procedures not included in the capitation, though all services should be documented on the claim form.

Minor Consent Services: Minor Consent Services, described below, may be billed fee-for-service (FFS) except when rendered by a PCP to their capitated members.

Minor Consent Services include:

- Confirmation or rule out pregnancy
- Family planning, including medically emergent abortions
- HIV testing
- Sexual assault
- Sexually transmitted diseases

Sterilization Services (Medi-Cal Only): California law (Title 22, Sections 51305.1 and 51305.4) requires that Medi-Cal beneficiaries who request sterilization surgery complete a form (PM-330) attesting that they are giving informed consent for the procedure. PM-330 forms must be completed and signed **30 days** prior to the surgery and filed in the medical record. Medi-Cal members may not waive the **30-day** waiting period. California law requires that a copy of the signed 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 until an appropriately completed PM-330 consent form is submitted by the primary surgeon.

Vaccines: Administration of routine pediatric immunizations is paid fee-for-service (FFS) to the PCP. The appropriate administration codes must be submitted on the CMS 1500. For Medi-Cal members, PCPs have access to free vaccines through the Vaccines for Children (VFC) Program.

To enroll, please visit the VFC Program's website at **www.cdc.gov/vaccines/programs/vfc/providers/index.html**.

Vaccines not covered by the VFC Program should be sent to the Alliance for reimbursement.

Laboratory — Clinical, Cytopathology, and Pathology: Quest Diagnostics is the Alliance's contracted partner for most outpatient clinical laboratory services. Except for emergency and urgent care services, and those lab services identified as covered under PCP capitation or specifically identified as reimbursed fee-for-service (FFS), laboratory services must be provided by Quest.

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, out-patient hospital, or free- standing surgical facility setting.

Office-Based Injectables: Except for injectables administered in an inpatient setting, claims for injectables administered in the office must include the National Drug Code (NDC) as published by the U.S. Food and Drug Administration (FDA) website. Claims that do not include NDCs or have invalid NDCs will be denied.

Office-based injectables are reimbursed in the following manner:

- Medi-Cal rates for Alliance Medi-Cal and Group Care members.
- If a Medi-Cal rate does not exist for a particular drug, refer to your contract for the Average Wholesale Price (AWP) percent.

Medical Supplies and Durable Medical Equipment:

The Alliance contracts with California Home Medical Equipment (CHME) for authorization, management, and servicing for the majority of DME and medical supply services to all members in all medical groups, except Kaiser.

CHME manages the following service categories:

- Breast pumps
- Home respiratory equipment
- Hospital beds
- Incontinence supplies
- Nutritional supplements and feeding supplies
- Wheelchairs, walkers, and canes
- Other home medical supply needs

Please submit to California Home Medical Equipment (CHME) by **one (1)** of the following ways:

Toll-Free: **1.844.583.4049**
Email: **aaorders@chme.org**

For providers with a contract for medical supplies, claims for medical supplies, including disposable gloves, incontinence, ostomy, tracheostomy, wound care, and urological supplies, must be submitted in the following manner:

- Level II HCPC codes are required.
- The Universal Product Number (UPN) for each item is required.
- Electronic medical supply transactions must be submitted in the 837 4010A1 professional format.

Medical supplies are reimbursed in the following manner:

- As determined by the provider's contract

Complaints

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

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

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

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

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

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

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

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

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

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

Alameda Alliance for Health
Claims Department – Notice of Provider Dispute Unit
P.O. Box 2460
Alameda, CA 94501-4506
Phone Number: **1.510.747.4530**

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

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

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

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

- Please sort disputes by similar issue.
- Provide a cover sheet for each batch.
- Number each cover sheet.
- Please include a cover letter for the entire submission describing each dispute with references to the numbered cover sheets.

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

Appeals of Utilization Management Decisions

The Alliance has an established process for receipt and review of appeals of Utilization Management (UM) Department decisions. Providers may appeal decisions to deny, modify, terminate, and defer requests on behalf of members. Appeals of these decisions are processed by the Alliance's Grievances & Appeals (G&A) Department, which can be reached via phone at **1.510.747.4531** or fax at **1.855.897.7174**.

Time Period for Submission of Appeals of UM Decisions: Appeals must be received by the Alliance G&A Unit within **60 days** of the UM Department's decision to deny, modify, terminate, or defer a request.

Required Information: At a minimum, each appeal must contain the provider's name, provider's contact information, the member's name and identification number, and a clear explanation of the basis upon which the provider believes that the decision should be reconsidered. Medical records supporting the appeal should also be included.

Acknowledgment of Appeals: The Alliance G&A Department acknowledges receipt of all appeals from contracted providers within **5 (five) calendar days** of the date of receipt.

Time Period for Resolution and Written Determination of an Appeal: Within **30 calendar days** from the date of receipt of the appeal or the amended appeal, the Alliance G&A Department will issue a written determination which will state the reasons for the Alliance's decision.

Provider Discharge of Member Process

The Alliance allows PCPs and specialists to request discharge of members when medical services can no longer be successfully provided for reasons other than medical conditions. The Alliance works with each discharged member to choose another PCP or specialist who can best meet their needs.

The process for discharging a member is described below:

1. PCPs/specialists must send member discharge requests to the Alliance Provider Services Department in writing. Please include complete documentation regarding the nature of the problem and reason for the requested discharge. The Alliance Provider Services Department will review the request and notify the PCP/specialist of the decision.
2. PCPs/specialists may only request the discharge of a member if medical care can no longer be successfully provided for reasons other than the member's medical conditions. Requests to discharge a member due to medical conditions, frequent visits, or high cost of care will be denied.
3. When the discharge request is acknowledged in writing, 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/specialist.
4. The original assigned PCP/specialist must maintain responsibility for the member's care until reassignment is completed but for no more than **30 days**. This responsibility includes giving the patient **30 days** written notice of the discharge.
5. The member discharge notice must state the following:
    - That the PCP/specialist will be available for emergencies and prescriptions for 30 days or until a new PCP/specialist assignment is effective;
    - That the member should contact the Alliance Member Services Department for assistance with selecting a new PCP/specialist; and

- That the PCP/specialist will make the member's medical records available to the member's new PCP/specialist upon request.

6. A copy of the member discharge letter that the PCP/specialist plans to send to the member once the discharge is granted must be sent to the Alliance Provider Services Department along with the initial discharge request.

7. If the PCP/specialist or the member is dissatisfied with the Alliance's decision, the PCP/specialist or member may file a grievance.

Member Grievance Process

A provider aware of a member with a problem or complaint about the Alliance, its policies, or its providers, should do the following:

1. Inform the member that they can call the Alliance Member Services Department at **1.510.747.4567**.
2. Give the member a Complaint Form and a copy of the "Member Guide to the Complaint/Grievance Process." Copies of the Complaint Form and the "Member Guide to the Complaint/Grievance Process" are included in the **Attachments** section.

Grievance forms in the Alliance's threshold languages (English, Spanish, Chinese, and Vietnamese) can also be found on the Alliance website at **www.alamedaalliance.org**.

The Alliance will acknowledge receipt of the member's complaint within **five (5) calendar days** and offer a resolution or status within **30 calendar days**. A member who files a complaint or grievance may not be discriminated against and cannot be disenrolled from the Alliance solely based on filing a complaint or grievance.

Additional Options

Alliance members also have these other options if they have a complaint:

- State Fair Hearings (Medi-Cal only) are administered by the California Department of Social Services, State Hearings Division. Medi-Cal beneficiaries may also request a State Fair Hearing through the Alameda County Social Services Agency.

  The request for a hearing must be made within **120 days** of the action in question. Additional information can be found at **www.dhcs.ca.gov/services/medi-cal/pages/medi-calfairhearing.aspx**.

  Alliance members can request a State Fair Hearing via mail or call to request a form.

  California Department of Social Services State Fair Hearings Division
  P.O. Box 944243, MS 19-37
  Sacramento, CA 94244-2430

Toll-free: **1.800.952.5253**
People with hearing or speaking impairments (TDD): **1.800.952.8349**

- Medi-Cal Managed Care Division Office of the Ombudsman can assist with enrollment and other problems.

  For more information, please call:

  Medi-Cal Managed Care and Mental Health Office of the Ombudsman
  Monday – Friday, 8 am – 5 pm; excluding holidays
  Toll-Free: **1.888.452.8609**

- Department of Managed Health Care (DMHC) is the state agency that regulates health plans like the Alliance. This option should be used after completing the plan's grievance process, except where there is an emergency, an unsatisfactory resolution by the plan, or the plan has not resolved a member's complaint within **30 days**.

- Members may also contact DMHC in emergency situations without going through the plan's process:

  The California Department of Managed Health Care (DMHC) Call Center
  24 hours a day, 7 days a week
  Toll-Free: **1.888.HMO.2219**
  People with hearing and speaking impairments (TDD): **1.877.688.9891**

  The HMO Help Center can provide help in many languages. For complaint forms and instructions, please visit the DMHC website at **www.hmohelp.ca.gov**.

  The HMO Help Center can also assist with a request for an Independent Medical Review (IMR). This is an administrative procedure that allows a member to present evidence for independent medical review. The reviewers are certified by DMHC. Alliance Medi-Cal members may request an IMR if a State Fair Hearing has not been initiated and the member has completed the plan's grievance process.

We Are Here to Help You

Thank you for joining the Alameda Alliance for Health's provider network! Together, we are creating a healthier community for all.

If you have any questions or concerns, please contact:

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

Attachments

The following documents are included as attachments to this guide. Many resources can be found on the Alliance's website at **www.alamedaalliance.org**.

- Sample Alliance Member Identification (ID) Cards
- Provider Portal Sign-Up Instructions
- Provider Portal Instruction Guide
- Claims FAQs
- Important Contact Numbers
- Alliance Authorization Request Form
- Medication Request Form for Alliance Medi-Cal and Group Care members
- Alliance Specialty Pharmacy Program Drug List
- Notice of Provider Dispute Form
- Member Grievance Forms (English, Spanish, Chinese, Vietnamese)
- Member Rights & Responsibilities
- Standard Timely Access Requirements
- Health Education Forms and Documents
- Interpreter Services Guide and Documents
- PCP Change Request Form and Memo
- Advice Nurse Line for Alliance Medi-Cal and Group Care members
- Non-Emergent Ground Transport
- Electronic Funds Transfer (EFT) Form
- Electronic Remittance Advice (ERA) Enrollment Form
- Electronic Data Interchange (EDI) Form