2022 Quarter 4 Provider Packet
In-Person Visits by Provider Services Have Resumed!

The Alliance is pleased to report that we have resumed in-person visits. Provider Relations Representatives are available to meet with you in person, by phone, and by virtual meetings.

Here are ways that you can access Alliance updates and reach out to us for assistance:

- Contact your Provider Relations Representative directly by email or phone
    - Errin Poston: **eposton@alamedaalliance.org**, **1.510.747.6291**
    - Stacey Woody: **swoody@alamedaalliance.org**, **1.510.747.6148**
    - Tom Garrahan: **tgarrahan@alamedaalliance.org**, **1.510.747.6137**
    - Leticia Alejo (Delegated Groups/Hospitals): **lalejo@alamedaalliance.org**, **1.510.373.5706**
1. Email us at **providerservices@alamedaalliance.org**
2. Call our Provider Call Center at **1.510.747.4510**
3. Visit the provider section of our website at **www.alamedaalliance.org/providers**

THIS PACKET INCLUDES:

- Provider *Did You Know?* Notices
- Provider Demographic Attestation Form
- 2022 Seasonal Influenza Vaccine Notice and 2022-2023 Covered Flu Vaccine List
- Timely Access Standards
- Important Notice: The Alliance Is Insourcing Mild-to-Moderate and Autism Spectrum Disorder (ASD) Behavioral Health Care Services
- Mild-to-Moderate Behavioral Health Insource Provider Services FAQ
- Opioid Academic Detailing Provider Materials
- Member Responsibilities and Rights
- 2021 HEDIS® Results
- Important Update: Required Information for Home Health (HH) Prior Authorization Requests
- Important Reminder: New Tertiary-Quaternary (TQ) Process for Alliance Providers and Specialists Referring Members to Academic Centers
- Outpatient Rehab (PT, ST, OT, Cardiac, Pulmonary, and Aquatic) Codes that Require Authorization
- Podiatry Procedure Codes that Require Authorization
- Pharmacy Substance Use Disorder (SUD) Cover Letter

☐ Accepting New Patients ☐ Accepting Existing Patients ☐ Not Accepting Patients

Comments: _____

_____

Provider/Office Staff Print: _____

Provider/Office Staff Signature: _____

DID YOU KNOW? *WE ARE HERE FOR YOU*

2022

Your Satisfaction Is Our Priority

At Alameda Alliance for Health (Alliance), we value our dedicated provider community. We are committed to continuously improving our provider satisfaction.

We are always here for you. We strive to provide the highest levels of customer service to our provider partners. Every year the Alliance conducts a provider satisfaction survey to help us learn how we can serve you better. We use these results to learn what is working and what we need to improve. **When you speak, we listen.**

About This Survey

Who: Alliance network providers including primary care providers (PCPs), specialists, and behavioral health providers. Survey respondents include nurses and other provider office staff, physicians, office managers, and behavioral health clinicians.

What: The survey measures how well we are meeting your expectations and needs, within various Alliance service areas, and open-ended feedback around ways in which the Alliance can improve its service to your organization.

When: The survey is fielded **annually between September and November**.

Why: Information obtained from these surveys helps the Alliance serve you better.

How: Surveys are completed through a third-party vendor, by mail and online, with follow-up phone calls to non-respondents.

Below are the areas that we measure as part of the survey:

- Call center staff
- Overall Satisfaction, compared to other health plans
- Network coordination of care
- Pharmacy
- Provider relations
- Reimbursement and claims
- Utilization and quality management

We strive to continue to get better and we want you to know what we have learned and improved. Over the next several weeks we will share key takeaway ***Did You Know*** facts with you, and we hope that you will continue to help make us stronger, together.

ALAMEDA Alliance FOR HEALTH

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm | Phone Number: **1.510.747.4510**
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PS_2022 PSC 07/2022

DID YOU KNOW? WE ARE HERE FOR YOU

The Alliance successfully launched the programs to provide additional support to members for Enhanced Care Management (ECM), Community Supports (CS), and Major Organ Transplant (MOT) services.

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The ECM, CS, and MOT programs and additional services were launched in 2022 as part of the CalAIM initiatives.

Year to date, the Alliance has serviced 1,139 members in ECM and has 8 ECM providers.

987 members successfully transitioned from the Health Homes and Whole Person Care programs to ECM.

The Alliance offers 6 CS services, which include:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Asthma Remediation
- Medical Respite
- Medically Tailored Meals

Year to date, the Alliance has serviced 149 members in CS and has 6 CS providers.

For more information on ECM, please visit **www.alamedaalliance.org/members/medi-cal/enhanced-case-management-ecm.**

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DID YOU KNOW? WE ARE HERE FOR YOU

The Alliance has a dedicated Provider Call Center and Provider Relations representatives available to assist you.

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We continue to increase our provider network to meet the needs of our members and increase access by creating a dedicated Provider Call Center. Our Provider Relations representatives help ensure that our providers have the support they need.

In July 2021, the Provider Call Center launched a callback feature to reduce hold time. This allows providers to hold their place in line and receive a return call once it is their time to speak with a Provider Relations representative. The Provider Call Center received and assisted more than 850 callback requests.

The Provider Call Center also implemented an after-call survey feature for providers to rate their satisfaction with the call and provide on-the-spot feedback. As of June 2022, the Provider Call Center satisfaction is rated 8 out of 10, or an 80% satisfaction rate.

Provider Relations representatives help with one-to-one support by phone, email, virtual meetings, and in person. They can help answer questions, guide you to the right resource, and provide initial and ad-hoc training.

In 2020, the Alliance began working remotely due to the pandemic. However, Provider Relations representatives continued to check in with providers virtually. In 2021, Provider Relations representatives completed **3,077** check-ins with our provider network.

Between January 1, 2022, and June 2022, Provider Relations representatives completed **1,248** check-ins with our provider network.

On average, we check in with our providers 257 times every month.

The Alliance Provider Services Call Center is available Monday – Friday, 7:30 am – 5 pm at **1.510.747.4510**.

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DID YOU KNOW? **WE ARE HERE FOR YOU**

Did you know the Alliance offers a Pay-for-Performance (P4P) program and no-cost interpreter services to our members?

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In 2020, $4.6 million was awarded to our primary care providers (PCPs) who participated in the P4P program.

The Alliance offers support to our providers in moving your quality performance forward using the Plan-Do-Study-Act (PDSA) method.

For example, over 3,000 telephonic, video, and in-person, interpreter services are provided each month, and a better patient understanding can help improve quality scores.

Learn how to access no-cost interpreters for Alliance members at **www.alamedaalliance.org/providers/provider-resources/language-access**.

To learn more about our no-cost health education literature, links, and tools to support member wellness and disease self-management that help improve patient health and overall quality scores, please visit our website at **www.alamedaalliance.org/providers/patient-health-wellness-education**.

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DID YOU KNOW? **WE ARE HERE FOR YOU**

Did You Know? The Alliance is beating benchmarks with claim payment.

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Regulatory Requirement – 90% of clean claims are required to be processed within 30 calendar days. The Alliance's 12-month average is 97.7%.

Regulatory Requirement – 95% of all claims are required to be processed within 45 working days. The Alliance's 12-month average is 99.9%.

The average turnaround time from receipt to payment is 18.5 days.

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DID YOU KNOW?

WE ARE HERE FOR YOU

Did you know that the Alliance receives more than 1.9 million claims every year?

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The Alliance receives more than **7,000** claims a day, almost **37,000** a week, **162,000** a month, and more than **1.9 million** claims every year – and we do it right, with **98%** accuracy every time.

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DID YOU KNOW? WE ARE HERE FOR YOU

Did You Know? The Alliance offers several services electronically and through our Provider Portal.

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If you want to get paid faster, sign-up for **Electronic Funds Transfer (EFT)**.

If you want to submit claims faster, sign-up for **Electronic Data Interchange (EDI)** to send claims to us electronically.

If you want to receive your **Remittance Advice (RA)** faster, sign-up for electronic RA.

Our Provider Portal allows you to:

- View and submit authorizations electronically
- View claim status and retrieve your RA
- View their gap-in-care reports
- Search for other providers through the Provider Directory

To request access to the Provider Portal or to enroll in any of the above services, please visit **www.alamedaalliance.org/providers**.

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DID YOU KNOW? WE ARE HERE FOR YOU

Did You Know? The Alliance is currently working on the mild to moderate mental health transition that will go live Saturday, April 1, 2023.

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Effective **Saturday, April 1, 2023,** behavioral health services will be administered directly by the Alliance and we will no longer contract with Beacon Health Options (Beacon). The Alliance will perform all administrative services previously handled by Beacon including contracting with Behavioral Health (BH) and Autism Spectrum Disorder (ASD) providers.

We have conducted listening sessions with Federally Qualified Health Centers (FQHCs) and community stakeholders to get input on areas of improvement.

There will be no change in the benefit. Serious Mental Illness (SMI), a behavioral health benefit, will continue to be carved out to the California Department of Health Care Services (DHCS) and will continue to be managed by Alameda County Behavioral Health Care Services (ACBH).

The Alliance and ACBH have a Memorandum of Understanding (MOU) that outlines how we can work together to provide behavioral and mental health services to Alliance members.

Phase 1 will be transitioning the network and contracting with the providers directly so that no members experience a disruption in care. We will then quickly focus on care integration and increasing access to mental and behavioral health services for our members.

We are excited to develop a direct relationship with the behavioral health providers that treat our members and improve care coordination.

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DID YOU KNOW?

WE ARE HERE FOR YOU

Did You Know? The Alliance is participating in the Coordination of Benefits Act (COBA) for secondary claim processing. We successfully completed the launch in 2021.

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The Alliance automatically receives and processes secondary claims from Medicare for CPT codes that cross over without you having to submit paper claims. This greatly reduces the number of paper claims required for our providers to send to us directly.

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DID YOU KNOW?

WE ARE HERE FOR YOU

Did you know? Our team has completed several initiatives to improve patient care.

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COVID-19 VACCINATION

From Wednesday, December 1, 2021, to Saturday, January 29, 2022, the Alliance collaborated with Haller's Pharmacy to improve COVID-19 vaccination rates for our members in Alameda County. Through our targeted outreach attempts, we were able to increase the vaccination rate by **7%**.

We also distributed more than **$1.4 million** back to our community and providers to help improve COVID-19 vaccination rates. In addition, with the help of the California Department of Health Care Services (DHCS) funding, we gave member and provider incentives to increase the COVID-19 vaccination rate for Alliance members.

OPIOID STEWARDSHIP CAMPAIGN

The Alliance successfully launched an opioid stewardship campaign to provide resources to members who are chronic opioid users, and providers to help taper patients on chronic opioids. This was launched in December 2020 and continued through 2021. Year to date, this Alliance program has helped **76** members and **31** provider groups.

ASTHMA

The Alliance has worked to improve drug adherence for **200** Black African American adults with asthma between 21 to 44 years of age, with an asthma medication possession rate of **50%** or below. The intervention took place between April 2021 to September 2021. A total of **11** members agreed to participate in our survey and **10** out of the **11** improved their AMR scores. **Two out of 11** members had asthma-related emergency department (ED) visits after our outreach intervention (e.g., coordinating primary care provider (PCP) appointments, education on the importance of control inhalers, and disease state management, 90-Day Maintenance List, and pharmacy consultation).

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ALAMEDA Alliance FOR HEALTH

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Provider Demographic Attestation Form

The Alameda Alliance for Health (Alliance) Provider Demographic Attestation Form is confidential. Filling out this form will help us better serve you. Please only complete the form if there are any changes.

INSTRUCTIONS:

1. Please type or print clearly.
2. Please complete the form and return by fax to the Alliance at **1.855.891.7257**.

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

PROVIDER INFORMATION		
Provider/Clinic Name:		Provider Tax ID:
Site Address:		
City:	State:	Zip Code:
Main Phone Number:		Fax Number:
Hours of Operation:		
Clinic Email Address:		
Languages Spoken:		Accepting Patients ☐ Yes ☐ No ☐ Only Existing

PROVIDER NAME	PROVIDER NPI	IS THIS PROVIDER STILL AFFILIATED WITH THIS PRACTICE?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

Date Update Completed (MM/DD/YYYY):

Notes:

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www.alamedaalliance.org

2022 Seasonal Influenza Vaccines

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider customer satisfaction.

The Alliance is pleased to cover the flu shot for eligible Alliance Group Care and Medi-Cal members. Eligible Alliance members can get a flu shot if supplies are available at your office.

Effective Thursday, September 1, 2022, the Alliance will reimburse providers for administering the Alliance formulary injectable seasonal flu vaccine to eligible Alliance Group Care and Medi-Cal members. The flu vaccine is available at no cost to eligible Alliance members.

The Alliance Formulary Flu Vaccine List is included with this notice and available on our website at **www.alamedaalliance.org/providers/pharmacy-formulary/resources**.

The flu vaccine for Medi-Cal members under the age of 19 should be covered through the Vaccines for Children (VFC) program. If you do not participate in the VFC program, the vaccination will be covered by the Alliance. While Medi-Cal members ages 65 years and older, flu vaccines should be covered through Medicare Part B. If the Medi-Cal member does not have Medicare Part B coverage, the vaccination will be covered by the Alliance.

Alliance members also have the choice to receive a flu vaccine from a retail pharmacy as follows:

1. **Alliance Group Care members** can get the flu vaccine from any Alliance-contracted retail pharmacy that administers flu vaccines. For help finding a network retail pharmacy, please visit **www.alamedaalliance.org/help/find-a-pharmacy**.
2. **Alliance Medi-Cal members** can get the flu vaccine from a pharmacy contracted with the California Department of Health Care Services (DHCS) Medi-Cal Rx Program. To view the Medi-Cal Rx contracted drug list or to find a Medi-Cal Rx pharmacy for Alliance Medi-Cal members, please visit **https://medi-calrx.dhcs.ca.gov/home/**.

Please encourage all patients to get their flu shot today.

If you have questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

Thank you for your ongoing partnership in protecting the health of our community.

ALAMEDA ALLIANCE FOR HEALTH
2022-2023 COVERED FLU VACCINE LIST

VACCINE NAME	CPT CODE	NDC	DOSAGE FORM	MANUFACTURER
Afluria Quad 2022-2023 (PF) 60 mcg (15 mcg x4)/0.5 mL – 3 years & up	90688	33332-0322-03	IM syringe	SEQIRUS
Afluria Quad 2022-2023 60 mcg (15 mcg x 4)/0.5 mL – 6 months & up	90688	33332-0422-10	IM suspension	SEQIRUS
Fluad Quad 2022-2023 60 mcg (15 mcg x 4)/0.5 mL – 65 years & up	90694	70461-0122-03	IM syringe	SEQIRUS
Fluarix Quad 2022-2023 (PF) 60 mcg (15 mcg x 4)/0.5 mL – 6 months & up	90686	58160-0890-52	IM syringe	GLAXOSMITHKLINE
Flulaval Quad 2022-2023 (PF) 60 mcg (15 mcg x 4)/0.5 mL – 6 months & up	90686	19515-0808-52	IM syringe	GSK-ID BIOMEDIC
Flumist Quad 2022-2023 10 exp 6.5-7.5 FF unit/0.2 mL – 2 to 49 years old	90672	66019-0309-10	Nasal Spray	MEDIMMUNE/ASTRA
Fluzone High-Dose Quad 2022-2023 (PF) 240 mcg/0.7 mL – 65 years old & up	90662	49281-0122-65 49281-0122-88	IM syringe	SANOFI-PASTEUR
Fluzone Quad 2022-2023 (PF) 60 mcg (15 mcg x 4)/0.5 mL – 6 months & up	90688	49281-0422-10 49281-0422-58	IM suspension	SANOFI-PASTEUR
Fluzone Quad 2022-2023 (PF) 60 mcg (15 mcg x 4)/0.5 mL – 6 months & up	90688	49281-0422-50 49281-0422-88	IM syringe	SANOFI-PASTEUR
Fluzone Quad 2022-2023 (PF) 60 mcg (15 mcg x 4)/0.5 mL – 6 months & up	90688	49281-0637-15 49281-0637-78	IM suspension	SANOFI-PASTEUR

PLEASE NOTE:

- Effective Saturday, January 1, 2022, the California Department of Health Care Services (DHCS) will manage the Medi-Cal pharmacy benefit instead of the Alliance. The new program is called "Medi-Cal Rx."
- There is a quantity limit of one (1) vaccine per member per 270 days, across all flu vaccine formulations.

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Timely Access Standards*

Alameda Alliance for Health (Alliance) is committed to working with our provider network in offering our members the highest quality of health care services.

Timely access standards* are state-mandated appointment timeframes for which you are evaluated. All providers contracted with the Alliance are required to offer appointments within the following timeframes:

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
OB/GYN Appointment	10 Business Days of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service** Provider	15 Business Days of Request
OB/GYN Appointment	15 Business Days of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of 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.	

*** Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines PA = Prior Authorization**

Urgent Care refers to 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 refers to routine appointments for non-urgent conditions.

Triage or Screening refers to 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 their 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.

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Important Notice: The Alliance is Insourcing Mild-to-Moderate and Autism Spectrum Disorder (ASD) Behavioral Health Care Services

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important announcement that we would like to share with you regarding behavioral health care services.

Effective Saturday, April 1, 2023, behavioral health services will be administered directly by the Alliance, and we will no longer contract with Beacon Health Options (Beacon). This means the Alliance will perform all administrative services previously handled by Beacon, including contracting with behavioral health (BH) and autism spectrum disorder (ASD) providers.

There will be no change in the benefit.

For **Alliance Medi-Cal** members, the Serious Mental Illness (SMI) behavioral health care benefit will continue to be carved out to the California Department of Health Care Services (DHCS) and managed by Alameda County Behavioral Health Care Services (ACBHS). The Alliance and ACBHCS have a Memorandum of Understanding that outlines how we work together to provide behavioral and mental health services to Alliance members.

For **Alliance Group Care** members, we will be responsible for all behavioral health care services.

At the Alliance, we are excited to develop a direct relationship with the behavioral health care providers who treat our members and to improve care coordination. We have included with this notice the *Alliance Mild-to-Moderate Behavioral Health Provider Services Frequently Asked Questions (FAQ*) to help provide more details about this change.

Thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a safer and healthier community for all.

Questions? Please call the Alliance Provider Services Department
or you may contact your Provider Representative directly
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ALAMEDA ALLIANCE FOR HEALTH

Mild-to-Moderate Behavioral Health Insource Provider Services FAQ

Overview

Since 2013, Alameda Alliance for Health (Alliance) has contracted with Beacon Health Options (Beacon) to administer the mild-to-moderate Behavioral Health (BH) and Autism Spectrum Disorder (ASD) benefit. Effective **Saturday, April 1st, 2023**, these services will be administered directly by the Alliance. This means that the Alliance will perform all administrative services previously handled by Beacon including contracting with BH/ASD providers.

Serious Mental Illness (SMI) is a behavioral health benefit that is carved out to the California Department of Health Care Services (DHCS) and will continue to be managed by Alameda County Behavioral Health Care Services (BHCS).

The Alliance and Alameda County BHCS have a Memorandum of Understanding (MOU) that outlines how we work together to provide behavioral and mental health services to Alliance members.

Q: The Alliance serves two lines of business, Medi-Cal and Group Care. How will this change impact the Alliance Medi-Cal program?

A: For the Alliance Medi Cal program, Alameda County BHCS will remain responsible for moderate-to-severe specialty mental health SMI service levels of care. Including inpatient psychiatric and crisis services. However, starting **Saturday, April 1st, 2023**, Alliance Medi-Cal members will access all mild-to-moderate non-specialty mental health service levels of care, including outpatient behavioral health services, through the Alliance.

The Alliance and Alameda County BHCS are also working to implement the new DHCS "No Wrong Door (NWD) for Mental Health Services Policy" that takes effect on **Saturday, July 1st, 2022**, to help ensure that Medi-Cal members can easily access the services they need no matter where they seek help.

Q: How will this change impact the Alliance Group Care program?

A: For the Alliance Group Care program, access to all behavioral health services will be through the Alliance. The Alliance is responsible for all levels of behavioral health care, including inpatient and outpatient services

Q: Will Alliance members need to change their BH/ASD provider?

A: We aim to prevent any disruption in care**.** The Alliance will reach out to all currently contracted providers seeing Alliance members. Alliance members may still be able to see the same provider through the Alliance network or "continuity of care" agreements for up to 12 months. The Alliance will also help members find a new provider if needed.

Q: How can Alliance members and providers find a new BH/ASD provider?

A: The Alliance will list all directly contracted BH/ASD providers in the Alliance network in the printed and online Alliance provider directory. The Alliance Member Services Department can also help members and providers find a BH/ASD provider in our network.

Q: Will the benefit change for Alliance members?

A: No. The Alliance will maintain the existing benefit that has been managed by Beacon. The Alliance will take over direct responsibility for supporting members and providers.

Q: What is the effective date of this change?

A: Saturday, April 1st, 2023.

Q: Can members continue to self-refer to receive BH/ASD services?

A: Yes. Alliance members can continue to self-refer to receive BH/ASD services.

Please refer your members to call:

Alliance Member Service 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**

Q: Can a provider refer a member for case management if they have complex BH needs?

A: Yes. Providers can refer Alliance members for case management if they have complex BH needs.

Providers may refer members 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**

Q: How will a member know if they qualify for mild-to-moderate (from the Alliance) or moderate-to-severe (from Alameda County BHCS) services?

A: Both the Alliance and Alameda County BHCS screen for the correct level of care based on the severity of a member's condition. We provide the screening tool to our contracted mental health providers to help determine if a member meets the criteria for treatment from Alameda County BHCS.

Also, starting on **Friday, July 1st, 2022**, the new DHCS NWD for Mental Health Services Policy" will allow Alliance Medi-Cal members to initiate non-specialty mild-to-moderate and specialty moderate-to-serve mental health services through the Alliance or our Alameda County BHCS Partners.

Q: Will any BH services require authorization?

A: Authorization is not required for a mental health evaluation provided by a contracted Alliance mental health provider. However, prior authorization is required based on medical necessity criteria for psychological testing and behavioral health therapy (BHT)/Applied Behavioral Analysis (ABA) services.

Q: Will ASD services require authorization?

A: Yes. Prior authorization is required based on medical necessity criteria for a comprehensive diagnostic evaluation or psychological testing and BHT/ABA services.

Q: How will our provider network know about this change?

A: Providers will be informed through the following:

1. Alliance Provider Manual
2. Alliance Quarterly Provider Updates
3. Alliance Website – Provider Section
4. Alliance New Provider Orientation Documents
5. Provider Notices – 30-, 60-, and 90-day notices via fax and email

Q: Will BH/ASD providers receive training about the Alliance and its benefits?

A: Yes. The Alliance will conduct training for all newly credentialed providers within 10 days of their effective date. Training materials will be made available and posted to the Alliance public website.

Q: Can members receiving BHT/ABA services for Autism Spectrum Disorder continue treatment with their Qualified Autism Service Provider?

A: Yes. The Alliance aims to contact all existing BHT/ABA providers currently seeing Alliance members.

Q: Who can BH/ASD providers contact for more information or if they have questions?

A: For questions or more information, BH/ASD providers may contact:

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

ALAMEDA ALLIANCE FOR HEALTH

BENZODIAZEPINE TAPER DECISION TOOL – CLINICIAN'S GUIDE

WE ARE HERE TO HELP YOU!

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community, and we appreciate all of your hard work to improve health and wellbeing in our community.

We have created a Benzodiazepine Taper Decision Tool and reference guide to help clinicians determine:

- If a benzodiazepine taper is necessary.
- When to perform the taper.
- When to provide follow-up and support during the taper.

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ALAMEDA Alliance FOR HEALTH

Benzodiazepine Tapering

Combining both opioids and benzodiazepines can be dangerous because both drugs cause sedation and respiratory depression.[1] Long term use of benzodiazepines could increase the risk of cognitive impairment, delirium, falls, fractures and motor vehicle crashes especially in older adults.[2] In 2015, 23% of people who died of an opioid overdose also tested positive for benzodiazepines.[3]

Populations of Who to Taper[4]

- Those with a combination of benzodiazepines, opioids, and/or amphetamines.
- Those who demonstrate an active use or history of substance use disorder.
- Older patients.
- Those with a cognitive disorder or traumatic brain injury.

Patients who have been on benzodiazepines for 4-6 weeks should be considered for tapering. Patients who are concurrently taking routine opioids and benzodiazepines can be tapered separately or concurrently.

Specific Tapering Recommendations[4]

Individuals taking higher than recommended doses:

- Consider hospital monitoring to minimize medical risks.
- Consider switching to long-acting benzodiazepines.
- Reduce dose initially by 25-30%.
- Reduce dose by 5-10% daily to weekly.

Individuals taking therapeutic dose-bedtime dosing:

- Reduce by approximately 25% weekly.
- Anticipate and educate on rebound insomnia.
- Educate patient on sleep hygiene.
- Provide alternative options: CBT, non-benzodiazepines (trazadone).

Individuals taking therapeutic doses-daytime dosing (QD to QID):

- Anticipate and educate the patient on rebound anxiety and recurrence of initial anxiety symptoms.
- Plan additional psychological support during taper.
- Educate and prepare for the last phase of withdrawal, which will be the most difficult.
- Warn that dosing schedule changes (e.g. TID to BID) will be psychologically challenging.

- Initial dose taper between 10-25%.
    - Observe signs of withdrawals.
    - Anticipate and educate withdrawals with short-half life.
    - Individualize subsequent reductions based on individualized response.
- Follow with further reductions of 10-25% as tolerated pharmacologically.
    - The patient may need to taper slowly. Some patients may hold their dose for 1-2 months.

Adjunctive options to support the last phase of taper[4, 6, 7]

More research and trials are needed for supportive therapy. Options listed below are studies with the highest level of evidence:

- Carbamazepine, paroxetine
    - May reduce symptoms of anxiety
- TCA, paroxetine
    - May help with withdrawals
- TCA
    - Potentially positive effective on benzodiazepine discontinuation

Benzodiazepine Equivalency[2,4, 5]

DRUG	DOSE EQUIVALENCE	ELIMINATION HALF-LIFE (HOURS)	TYPE OF BENZO
Chlorodiazepoxide (Librium)	10 mg	14-95	Long
Diazepam (Valium)	5 mg	100	Long
Flurazepam (Dalmane)	15-30 mg	111-113	Long
Alprazolam (Xanax)	0.5 mg	11.2	Intermediate
Clonazepam (Klonopin)	0.5 mg	17-60	Intermediate
Lorazepam (Ativan)	1 mg	12	Intermediate
Temazepam(Restoril)	10-20 mg	3.5-18.4	Intermediate
Triazolam (Halcion)	0.25-0.5 mg	1.5-5.5	Short

Most studies in primary care have found that successful tapering greater than 10 weeks can lead to achieving long-term abstinence.[2]

Withdrawal symptoms: Agitation, anxiety, tachycardia, dysphoria, insomnia, hallucinations, delusions, delirium.[2]

Tapering Example[4]

Drug: Lorazepam 4 mg bid → Diazepam 40 mg qd

WEEK	DIRECTION	DOSAGE
Week 1		35 mg/day
Week 2	Decrease dose by 25%	30 mg/day (25%)
Week 3		25 mg/day
Week 4	Decrease dose by 25%	20 mg/day (50%)
Week 5-8	Hold dose for 1-2 months	Continue at 20 mg/day for 1 month
Week 9-10		15 mg/day
Week 11-12	Decrease dose by 25% at week 11	10 mg/day
Week 13-14	Decrease dose by 25% at week 13	5 mg/day
Week 15		Discontinue

References

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Disclaimer
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Email: **providerservices@alamedaalliance.org**

ALAMEDA ALLIANCE FOR HEALTH

SUBSTANCE USE DISORDER OPIOID TAPER DECISION TOOL – CLINICIAN'S GUIDE

WE ARE HERE TO HELP YOU!

At Alameda Alliance for Health (Alliance), we value our dedicated provider partner community, and we appreciate all of your hard work to improve health and wellbeing in our community.

We have created an Opioid Taper Decision Tool and reference guide to help clinicians determine:

- If an opioid taper is necessary.
- When to perform the taper.
- When to provide follow-up and support during the taper.

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ALAMEDA Alliance FOR HEALTH

High-Risk Population

Tapering off opioids can present a clinical challenge, especially for patients on a high dose of opioids (>90 MME), those with moderate to severe chronic pain (pain greater than 3 months), and those with co-existing mental health disease.[1]

The Centers for Disease Control and Prevention (CDC) recommends starting an opioid dose taper of 10% per week following the patient's functional and pain status each visit.[2] Some patients may need an even slower dose taper depending on the duration of their opioid use.

Providers should consider an opioid taper when the risk of treatment outweighs the benefit.

Consider tapering opioids in the following scenarios:[1, 2]

- Limited pain reduction or improvement in function on escalating doses.
- Severe side effects requiring intensive management.
- Concurrent use of opioids and benzodiazepines.
- Greater than 90 MME/day.
- Non-adherence to a treatment plan.
- Concern for substance use disorder:
    - Consider using any of the following tools: 4 C's Tool, Opioid Risk Tool, Patient Medication Questionnaire, Screener, and Opioid Assessment for Patients with Pain-Revised.[3]
- Opioid related overdose.
- Comorbid risk factors:
    - Lung disease, sleep apnea, liver disease, renal disease, fall risk, greater than 65 years old, mental health disease.
- Opioid tolerance (see below).

Definition of Opioid Tolerance[4]

Patients considered opioid-tolerant are those receiving any of the following medication for 1 week or longer:

- At least 60 mg oral morphine/day
- 25 mcg transdermal fentanyl/hour
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day

BRAVO Tool and Other Patient Counseling Tools

The BRAVO protocol outlines a safe and compassionate strategy for opioid tapering while maintaining therapeutic compliance.[5]

BRAVO Tool[5,6]:
www.oregonpainguidance.org/wp-content/uploads/2020/04/BRAVO-FINAL-3.13.20.pdf
www.oregonpainguidance.org/wp-content/uploads/2019/02/BRAVO-updated-2019.pdf?x91687

How to Taper Patients Off of Chronic Opioids Therapy CE:
www.edx.org/course/how-to-taper-patients-off-of-chronic-opioid-therapy

Changing Conversations About Pain CE:
www.oregonpainguidance.org/clinics/opmc-online-pain-management-course

Prescription Opioid Dependence vs Opioid Use Disorder

It is important to understand the difference between Prescription Opioid Dependence and Opioid Use Disorder.

Prescription Opioid Dependence[7] occurs when the body adjusts its normal functioning around regular opioid use. Unpleasant physical symptoms occur when medication is stopped.

Opioid Use Disorder[7] occurs when attempts to cut down or control use are unsuccessful or when the use of opioids results in social problems and a failure to fulfill obligations at work, school, and home. Opioid Use Disorder often comes after the person has developed opioid tolerance and dependence.

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Opioid Tapering Examples (For Reference Only)[4,8]

The CDC recommends a 10% opioid taper per month. Below are different slow tapering scenarios.

*Slow Taper (10% per month)[4]: Morphine **ER** 120 mg BID*

MONTH	MORPHINE ER TAPERED DOSE
Month 1	210 mg (120 mg +90 mg)
Month 2	180 mg (90 mg bid)
Month 3	150 mg (75 mg bid)
Month 4	135 mg (60 mg +75 mg)
Month 5	120 mg (60 mg bid)
Month 6	105 mg (60 mg +45 mg)
Month 7	90 mg (45 mg bid)

MONTH	MORPHINE ER TAPERED DOSE
Month 8	75 mg (45 mg +30 mg)
Month 9	60 mg (30 mg bid)
Month 10	45 mg (30 mg +15 mg)
Month 11	30 mg (15 mg bid)
Month 12	15 mg daily
Month 13	Discontinue

Tapering After Surgery[4]: After surgery, a patient is often ready for an opioid taper.

For example, if a patient is on Oxycodone 10/325 mg, 2 tablets every 6 hours (8 tabs/day), a slow taper is:

DAY	DIRECTIONS	# TABS
Day 1-4	2 tabs every morning, 2 tabs every lunch, 2 tab every dinner, 1 tab qhs	7 tabs/day
Day 5-8	2 tabs every 8 hours	6 tabs/day
Day 9-12	2 tabs every first 8 hours, 1 tab every last 8 hour	5 tabs/day
Day 13-16	1 tab every 6 hours	4 tabs/day
Day 17-20	1 tab every 8 hours	3 tabs/day
Day 20-23	1 tab every 12 hours	2 tabs/day
Day 24-27	1 tab daily	1 tabs/day
Day 28	Discontinue	0 tabs/day

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Tapering Methadone[4]: Methadone 40 mg every 8 hours

MONTH	METHADONE TAPERED DOSE
Month 1	30 mg every 8 hours
Month 2	20 mg every 8 hours
Month 3	15 mg every 8 hours
Month 4	10 mg every 8 hours
Month 5	10 mg daily before noon, 5 mg daily at noon, 10 mg daily in the afternoon or evening
Month 6	5 mg daily before noon, 5 mg daily at noon, 10 mg daily in the afternoon or evening
Month 7	5 mg daily before noon, 5 mg daily at noon, 5 mg daily in the afternoon or evening
Month 8	5 mg daily before noon, 5 mg daily at noon, 2.5 mg daily in the afternoon or evening
Month 9	5 mg daily before noon, 2.5 mg daily at noon, 2.5 mg daily in the afternoon or evening
Month 10	2.5 mg every 8 hours
Month 11	2.5 mg every 12 hours
Month 12	2.5 mg daily
Month 13	Discontinue

Tapering Fentanyl[4]: *Fentanyl 100 mcg every 72 hours*

Slower taper: Reduce by 25 mcg/hr every 30 days

MONTH	FENTANYL TAPERED DOSE
Month 1	75 mcg every 72 hours
Month 2	50 mcg every 72 hours
Month 3	25 mcg every 72 hours
Month 4	12 mcg every 72 hours*
Month 5	Discontinue

***Please Note:** Patient may need morphine 15 mg q6h to manage withdrawal symptoms. Package insert indicates that the patient may go into withdrawal symptoms while tapering.

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Treatment of Withdrawal Symptoms[1,Error! Bookmark not defined.]

INDICATIONS	TREATMENT OPTIONS*
Abdominal cramping	• Diclyclomine 20 mg q6-8h.
Aches, pains, myalgia	• NSAIDS, Acetaminophen, lidocaine 5% ointment, Diclofenac 1% gel.
Anxiety, lacrimation, rhinorrhea	• Hydroxyzine 25 mg to 50 mg tid prn. • Diphenahydramine 25 mg q6h prn.
Autonomic symptoms (sweating, tachycardia, myoclonus)	• Clonidine 0.1 or 0.2 mg q6-q8h prn. Hold if BP<90/60. Obtain daily BP check. Reassess in 3 to 7 days. Taper upon symptom resolution. Alternatives: • Baclofen 5 mg tid prn; may increase to 40 mg daily dose. • Gabapentin 100 mg to 300 mg titrated to 1800 to 2100 mg divided in 2 to 3 doses. • Tizanidine 4 mg tid prn, can increase to 8 mg tid prn.
Diarrhea	• Loperamide 2 mg to 4 mg prn up to 16 mg per day. • Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day.
Insomnia	• Trazodone 25 mg to 100 mg qhs.
Nausea/Vomiting	• Prochlorperazine 5 to 10 mg q4h prn. • Promethazine 25 mg po or pr q6h prn. • Ondansetron 4 mg q6h prn.

***Please Note:** All meds are on the Alliance formulary and do not require prior authorization (PA).

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Email: **providerservices@alamedaalliance.org**

WE ARE A PART OF YOUR HEALTH CARE FAMILY AND WE EACH HAVE A ROLE TO PLAY

Alliance Member Responsibilities and Rights

If you need help reading this document or would like a different format, please call the Alliance Member Services Department at **1.510.747.4567**.

Si necesita ayuda para leer este documento, o le gustaría tenerlo en un formato diferente, llame al Departamento de Servicios al Miembro de Alliance al **1.510.747.4567**.

如果您需要幫助閱讀此文檔或需要不同的格式，請致電Aliiance計畫成員服務處，電話：**1.510.747.4567**

Nếu quý vị cần giúp đỡ đọc tài liệu này hoặc muốn một định dạng khác, vui lòng gọi cho Ban Dịch vụ Hội viên Alliance theo số **1.510.747.4567**.

Kung kailangan mo ng tulong sa pagbasa ng dokumentong ito o kung gusto mo ng ibang format, mangyaring tumawag sa Alliance Member Services Department sa **1.510.747.4567**.

As an Alliance member, you have certain responsibilities.

MEMBERS RESPONSIBILITIES
To treat all the Alliance staff and health care staff with respect and courtesy.
To give your doctors and the Alliance correct information.
To work with your doctor. Learn about your health, and help to set goals for your health. Follow care plans and advice for care that you have agreed to with your doctors.
To always present your Alliance member identification (ID) card to receive services.
To ask questions about any medical condition, and make sure you understand your doctor's reasons and instructions.
To help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
To make and keep medical appointments and inform your doctor at least 24 hours in advance when you need to cancel an appointment.
To use the emergency room only in the case of an emergency or as directed by your doctor.

As an Alliance member, you have certain rights.

MEMBER RIGHTS
To receive information and advice about the Alliance, its programs, its doctors, the health care network, Advance Directive, and your rights and responsibilities.
To receive services and care without discrimination of race, color, ethnicity, national origin, religion, immigration status, age, disability, socioeconomic status, gender identity, or sexual orientation.
To be treated with respect at all times.
To keep your health information private, receive a copy, review and request changes to your health records.
To choose a doctor (also called a primary care provider or PCP) within the Alliance network and help make choices about your health care with your doctor. This includes the right to refuse treatment.
To talk freely with your doctors about treatment options for your health and help make choices about your health care with your doctor, this includes the right to refuse treatment.
To voice a grievance (or complaint) about the Alliance, its doctors, or the care we provide, or ask for a State Medi-Cal Fair Hearing.
To receive translation and interpreter services, and written information in other formats (audio, braille, large size print, etc.).
To have access to family planning services, Federally Qualified Health Centers (FQHCs), Indian Health Service (IHS) facilities, sexually transmitted disease services, emergency services outside the Alliance's network, Minor Consent services, and specialty services (i.e., durable medical equipment (DME)).
To leave the Alliance upon request at any time, subject to any restricted disenrollment period.
To continue to see your doctor if you are no longer covered by the Alliance under certain circumstances.
To be free from any form of restraint or rejection used as a means of pressure, discipline, convenience, or retaliation.
To use these rights freely without changing how you are treated by the Alliance, doctors, the health care network, or the state.
To access the Alliance Nurse Line, anytime, 24 hours a day, 7 days a week. Medi-Cal members: **1.888.433.1876**; Group Care members: **1.855.383.7873**.
To access telephone triage or screening anytime, 24 hours a day, 7 days a week, by calling your doctor.

As An Alliance member, you also have the right to receive timely access to care.

California Law requires the Alliance to provide timely access to care. This means there are limits on how long our members have to wait to receive health care appointments and telephone advice. The Alliance will do our best to ensure that you are best cared for and treated in a timely manner.

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
APPOINTMENT TYPE:	**APPOINTMENT WITHIN:**
Non-Urgent Appointment	10 Business Days of Request
First OB/GYN Prenatal Appointment	2 Weeks of Request
Urgent Appointment that requires PA	96 Hours of Request
Urgent Appointment that does not require PA	48 Hours of Request

SPECIALTY/OTHER APPOINTMENT	
APPOINTMENT TYPE:	**APPOINTMENT WITHIN:**
Non-Urgent Appointment with a Specialist Physician	15 Business Days of Request
Non-Urgent Appointment with a Behavioral Health Provider	10 Business Days of Request
Non-Urgent Appointment with an Ancillary Service Provider	15 Business Days of Request
First OB/GYN Prenatal Appointment	2 Weeks of Request
Urgent Appointment that requires PA	96 Hours of Request
Urgent Appointment that does not require PA	48 Hours of 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.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

PA = Prior Authorization

**Per Department of Managed Health (DMHC) and Department of Health Care Services (DHCS) Regulations, and National Committee for Quality Assurance (NCQA) Health Plan (HP) Standards and Guidelines*

Questions? Please call the 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**
www.alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

Alliance Member Responsibilities and Rights

WORDS TO KNOW

Ancillary Services – Health care services to support the work of a doctor. Services can be classified into three (3) categories: diagnostic, therapeutic, and custodial. Services can include diagnostic laboratory and X-ray services, chiropractic services, and hospice care.

Durable Medical Equipment (DME) – Certain medically necessary equipment that is for repeated use, for medical purpose, and/or generally not useful for someone who is not ill or hurt.

Emergency – The sudden start/onset of a medical condition or illness that is an immediate threat to the well-being of the patient. Conditions include but are not limited to chest pains, seizure or loss of consciousness, severe abdominal pain, sudden paralysis, uncontrolled bleeding, and active labor. If you have an emergency medical condition or psychiatric emergency, call 911 or go to the nearest hospital with an emergency room.

Emergency Care – An exam performed by a doctor (or other appropriate staff under the direction of a doctor as allowed by law) to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.

Expedited – To speed up the review process.

Grievance – An official written or verbal complaint filed with your medical provider if you are not happy with the behavior or actions of your plan or its representative (e.g., poor customer service, when an appeal process extends past the written date, etc.).

Life-threatening – Fatal or lethal illness or condition, if not attended to immediately, the likelihood of death is high. Conditions include but are not limited to difficulty breathing, shortness of breath, electrocution, gunshot wound, stabbing, sudden fainting, and severe allergic reactions.

Medical Interpreter/Translator – Individual who can help communicate spoken or signed language between the patient and the health care provider. The interpreter does not add, omit or change meaning or offer an opinion.

Medically Necessary – Services that are reasonable and needed to protect life, to prevent illness or disability, or to relieve severe pain, through the diagnosis or treatment of disease, illness, or injury.

Non-life-threatening – Illness or injury that does not require immediate attention/help (e.g., common cold, broken fingers or toes).

Non-Urgent Appointments – Schedule for routine care, check-up, or periodic health examination with your doctor or PCP, or would like to see a specialist, mental health provider, or for ancillary services.

Nurse Line – The free Advice Nurse Line is offered anytime, 24 hours a day, 7 days a week, to all members to help answer your health questions. The Advice Nurse Line links you to a registered nurse who can provide advice on health concerns such as treatment of common illnesses and conditions, tips on leading a healthy lifestyle, or information on health screenings and shots. The nurse can also help you decide what kind of care to seek, including: if your health problem can be treated at home, if you should see a doctor, or if you might need to get urgent or immediate care. Advice Nurse Line: Medi-Cal members: **1.888.433.1876**; Group Care members: **1.855.383.7873**.

Primary Care/Routine Care – Medically necessary services that are not urgent and help keep you healthy, such as check-ups, Well Child visits, and services to keep you from getting sick. The goal of routine care is to prevent health problems.

Triage Line – The Alliance Triage Line is offered anytime, 24 hours a day, 7 days a week, to all members to answer your health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional to help determine the urgency of the member's need for care.

Urgent Appointments – Schedule an appointment for a condition or illness that, if not attended to, could harm the patient's health in the future. Conditions include but are not limited to fever, ear/eye infection, minor cuts, broken bones, simple fractures.

Urgent Care – Medical care that is necessary to prevent serious deterioration of the health of a member, often resulting from an unforeseen illness, injury, or complication of an existing condition.

2021 HEDIS® Results

The Healthcare Effectiveness Data and Information Set® (HEDIS®) is used by health plans to measure how well services and care are provided to members. Annually, the Alliance collects data on how we perform certain services and types of care in collaboration with our provider partners. This data is reported to the National Committee for Quality Assurance (NCQA), which then rates our health plan.

The California Department of Health Care Services (DHCS) uses a subset of HEDIS® measures to hold health plans accountable and reports their performance. These measures are referred to as Managed Care Accountability Sets (MCAS). The chart below illustrates the 15 MCAS measures, the Alliance's performance rate, and the minimum performance level (MPL).

In 2021, the Alliance performed below the MPL on the following three (3) measures:

- Breast Cancer Screening
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits for ages 15 Months to 30 Months

The Alliance Quality Improvement (QI) Department is driving multiple initiatives to increase rates in measures below the MPL, including member outreach (e.g., phone calls, text messaging, mailers, etc.), member incentives to complete screenings, and provider and member education.

NCQA Acronym	Measure	Alliance 2021 Claims Only	Alliance 2021 Claims + Chart Review	50% MPL
CBP	Controlling High Blood Pressure	33.91%	55.72%	55.35%
CCS	Cervical Cancer Screening	55.55%	61.52%	59.12%
CDC	HbA1c Poor Control (>9.0%)	37.30%	32.85%	43.19%
CIS	Childhood Immunization Status - Combo 10	44.31%	47.15%	38.20%
IMA	Immunization for Adolescents - Combo 2	45.14%	46.96%	36.74%
WCC	BMI Percentile	63.74%	86.61%	76.64%
WCC	Counseling for Nutrition	48.72%	84.70%	72.96%
WCC	Counseling for Physical Activity	46.36%	83.61%	69.53%
PPC	Timeliness of Prenatal Care	86.33%	92.00%	85.89%
PPC	Postpartum Care	78.98%	83.60%	76.40%
BCS	Breast Cancer Screening	**53.02%**		53.93%
CHL	Chlamydia Screening in Women - Total	63.46%		54.91%
W30	Well Child Visits in the First 15 Months	**44.08%**		54.92%
W30	Well Child Visits for age 15 Months- 30 Months	**63.73%**		70.67%
WCV	Child and Adolescent Well-Care Visit	51.64%		45.31%

Questions? Please call the Alliance Provider Services Department
or you may contact your Provider Representative directly
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Important Update: Required Information for Home Health (HH) Prior Authorization Requests

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important update for **all physicians** and **Home Health (HH) providers** that we would like to share with you regarding HH prior authorization (PA) requests.

In 2016, the Centers for Medicare and Medicaid Services (CMS) enacted specific requirements for all HH authorizations. These requirements were recommended by the Office of the Inspector General (OSG) and adopted by CMS to standardize, help ensure, and strengthen oversight of physician documentation for HH face-to-face encounters.

All of the required elements are available in the following publications:

1. Medicare Benefit Policy Manual (CMS can be viewed (CMS Pub. 100-02, Ch. 7)
   www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/bp102c07.pdf
2. Medicare Program Integrity Manual (CMS Pub. 100-08, Ch. 6, Section 6.2.6)
   www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf

The Alliance is following up with all our providers to make sure we receive PA requests that align with this regulation.

The standards require a basic set of information for all PA requests for the start of care and all ongoing services.

Physician Requirements

Start of Care	Continuing Care
1. Documentation of a face-to-face encounter with the treating physician within 90 days prior to the start of care date, or within 30 days following the start of care date. 2. Supporting documentation of the patient's medical needs and why HH is necessary. 3. Goals of therapy and level of services required. 4. Member must be homebound, require skilled nursing or therapy AND care or treatment can safely be given in the home. 5. For wound care: description of the wound, size, and treatment to date. 6. Durable medical equipment (DME) requirements if applicable.	1. Supporting documentation of the patient's continued need for HH services. 2. Goals for continued service. 3. Written order for continuing HH services from the attending physician actively treating the member. 4. Date of the last face-to-face encounter with the member.

Home Health Provider Requirements

Start of Care	Continuing Care
1. Documentation of a face-to-face encounter with the treating physician within 90 days prior to the start of care date, or within 30 days following the start of care date. 2. A current, completed OASIS/485 completion of Certificate of Medical Necessity for HH Services. 3. Supporting documentation of the patient's need for HH services: • Primary diagnosis for HH • Current medical status • Medication list • Recent hospitalization information if applicable • DME utilized and reason(s) required • Specific skilled nursing, therapist needs • Wound description, wound size, frequency of dressings 4. Treating physician order for HH.	1. Supporting documentation of the patient's need for home health services 2. A current Completed OASIS/485 3. Date of the last face-to-face encounter with the physician. 4. Evidence of ongoing supervision of treating physician 5. Written physician's order for continuing HH services from the attending physician actively treating the member and the clinical need for continuation of services. 6. Clinical information as outlined at the start of care: • HH notes for the last two (2) weeks of care • Most recent skilled nursing or therapy progress notes • Documented goals of ongoing treatment, frequency of services with estimated timeframe, and reasons why the member didn't reach goals.

We have outlined below the most common omissions and errors that may cause delays in a member's care:

- Inappropriate use of "urgent" level of care – Please do not level all PAs as urgent
  - State auditors evaluate misuse of the term
  - Creates a backlog of non-urgent cases preventing true urgent cases from getting prompt attention.
  - Misuse of the term can result in extensive communication needs for documentation and the risk of denial due to improper submission.
- Insufficient or missing clinical information necessary for review of the home health services, such as:
  - Lack of progress notes
  - Missing 485/current orders
  - Illegible documentation
  - Documentation is not current
  - Frequency orders do not match the request

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

1. Through the Alliance Provider Portal by visiting **www.alamedaallince.org**.
2. Via fax to the Alliance Authorization Department at **1.855.891.7174**.

Thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a safer and healthier community for all.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Important Reminder: New Tertiary-Quaternary (TQ) Process for Alliance Providers and Specialists Referring Members to Academic Centers

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important notice we would like to share with you.

On Saturday, October 1, 2022, the Alliance implemented a new Tertiary-Quaternary (TQ) Policy to help standardize the process for reviewing referrals and transitions to tertiary and quaternary centers. This also helps ensure consistency of all reviews, both internally and externally (delegates, hospitals, clinics), resulting in highly specialized care prevention that impacts illness and restores health to the highest physical or psychological function. The new policy also helps provide a timely transition of members to the right level of care at the right time. The Alliance only makes utilization management decisions based on the appropriateness of care and the existence of coverage.

Frequently Asked Questions (FAQs)

What does this mean for providers in the Alliance network?

An approved authorization will now be required for office visits at any level or consultation with an Alliance TQ provider.

Which providers need to obtain prior authorization (PA) before referring members to a TQ center?

All community-level primary care providers (PCPs) and specialists need prior authorization (PA) for any member they wish to refer to a TQ center for an office visit.

What is considered a TQ Academic Site?

Examples of TQ academics sites and the affiliated addresses are listed below:

1. UCSF Medical Center – 505 Parnassus Ave. SF 94143
2. UCSF Mission Bay - 1635 Owens St, San Francisco, CA 94158
3. UCSF Mt. Zion - 1600 Divisadero St, San Francisco, CA 94115
4. Stanford Center - 750 Welch Rd Ste 305, Palo Alto, CA 94304
5. Stanford Center - 300 Pasteur Dr, Stanford, CA 94305

What if my patient was receiving services from a TQ center before Saturday, October 1, 2022?

All consultations and office visits rendered on or after Saturday, October 1, 2022, will require PA. If an Alliance member is already receiving services and in treatment for an active episode of care prior to Saturday, October 1, 2022, the provider should submit a PA and indicate the care that is actively being received.

How and where do I submit PA requests?

- You can submit PA requests through either of the following ways:
    - Complete the general Alliance Prior Authorization (PA) Form and submit it by fax to the Alliance Utilization Management (UM) Department at **1.855.891.7174**.
    - Electronically through our Alliance Provider Portal. To access the Alliance Provider Portal, please visit **www.alamedaalliance.org**.

What information should be included with my request?

- Indicate the reason(s) why the member would require 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 a PA will remain the same. For delegated members, the PA request will be submitted to the delegated medical group.

For more information, please view the Alliance Provider Manual on our website at **www.alamedaalliance.org/providers/alliance-provider-manual** and/or the authorization section of our website at **www.alamedaalliance.org/providers/authorizations**.

Thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a safer and healthier community for all.

Important Update: Outpatient Rehab (PT, ST, OT, Cardiac, Pulmonary, and Aquatic) Codes That Require Authorization

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important update we would like to share with you.

Our provider partner satisfaction is a top priority. We are working to improve our Utilization Management and Claims processes to help ensure proper claim payment to our provider partners, and alignment of authorized services. To accomplish this goal, we are reviewing each benefit and we will be sending you updates, as the information is ready to share.

This communication provides an update on Outpatient Rehab (PT, ST, OT, Cardiac, and Aquatic) codes that require prior authorization (PA). This will affect claims with date(s) of service starting Monday, August 1, 2022, and onward. Enclosed with this notice is a code-specific list for Outpatient Rehab (PT, ST, OT, Cardiac, and Aquatic) codes that show which codes require PA. The list may include codes that newly require authorization and/or previously required authorization. This list can be found on our website at **www.alamedaalliance.org/providers/authorizations.** Please refer to our website for the most up-to-date information about codes or benefits that require authorization.

In addition to the codes, our claims system will also validate that claims received match the authorization when an authorization is required.

The following items will be validated:

- Member name
- Provider NPI
- CPT and HCPC coding
- Date(s) of service is within the authorized range
- Number of units and/or visits
- Place of service matches site of care submitted on the authorization request form

This update has been validated based on current and published billable coding for 2021 and was confirmed to be covered by the California Department of Health Care Services (DHCS).

If you have questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

Thank you for your continued partnership and for providing high-quality care to our members and the community.

Questions? Please call the Alliance Provider
Department Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4501**
www.alamedaalliance.org

ALAMEDA ALLIANCE FOR HEALTH REFERRAL AND PRIOR AUTHORIZATION (PA)
PROCEDURE CODES FOR OUTPATIENT REHAB (AQUATIC, CARDIAC, OT, PT, PULMONARY, AND ST)

Before services are provided, please check:

Member Eligibility ▪ Medical Group ▪ Benefit Coverage ▪ Contracted Provider ▪ Medi-Cal Excluded Code

Questions? Please call the Alliance Provider Services Department at **1.510.747.4510**

Please Note: Effective Monday, August 1, 2022, the **bold** procedure codes highlighted in gray require PA.

SERVICE CATEGORY	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	SUBMIT AUTHORIZATION REQUEST TO
Aquatic Therapy	97113	AQUATIC THERAPY/EXERCISES	The Alliance or Delegate
Cardiac Therapy	G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	The Alliance or Delegate
	G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session	The Alliance or Delegate
	93797	**Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitor (per session)**	**The Alliance or Delegate**
	93798	**Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)**	**The Alliance or Delegate**
Physical Therapy	97012	MECHANICAL TRACTION THERAPY	The Alliance or Delegate
	97014	ELECTRIC STIMULATION THERAPY	The Alliance or Delegate
	97016	VASOPNEUMATIC DEVICE THERAPY	The Alliance or Delegate
	97018	PARAFFIN BATH THERAPY	The Alliance or Delegate
	97022	WHIRLPOOL THERAPY	The Alliance or Delegate
	97024	DIATHERMY EG MICROWAVE	The Alliance or Delegate
	97026	INFRARED THERAPY	The Alliance or Delegate
	97028	ULTRAVIOLET THERAPY	The Alliance or Delegate
	97032	ELECTRICAL STIMULATION	The Alliance or Delegate
	97033	ELECTRIC CURRENT THERAPY	The Alliance or Delegate
	97034	CONTRAST BATH THERAPY	The Alliance or Delegate
	97035	ULTRASOUND THERAPY	The Alliance or Delegate
	97036	HYDROTHERAPY	The Alliance or Delegate
	97039	PHYSICAL THERAPY TREATMENT	The Alliance or Delegate
	97110	THERAPEUTIC EXERCISES	The Alliance or Delegate
	97112	NEUROMUSCULAR REEDUCATION	The Alliance or Delegate
	97113	AQUATIC THERAPY/EXERCISES	The Alliance or Delegate
	97116	GAIT TRAINING THERAPY	The Alliance or Delegate
	97124	MASSAGE THERAPY	The Alliance or Delegate
	97129	THER IVNTJ 1ST 15 MIN	The Alliance or Delegate
	97130	THER IVNTJ EA ADDL 15 MIN	The Alliance or Delegate
	97139	PHYSICAL MEDICINE PROCEDURE	The Alliance or Delegate

Please note: This list does not include all services.

SERVICE CATEGORY	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	SUBMIT AUTHORIZATION REQUEST TO
Physical Therapy (cont.)	97140	MANUAL THERAPY 1/> REGIONS	The Alliance or Delegate
	97530	**THERAPEUTIC ACTIVITIES**	**The Alliance or Delegate**
	97533	PT RE-EVAL EST PLAN CARE	The Alliance or Delegate
	97750	PHYSICAL PERFORMANCE TEST	The Alliance or Delegate
	97799	PHYSICAL MEDICINE PROCEDURE	The Alliance or Delegate
	G0151	SRVC PT HOM HLTH/HOSPICE EA 15 MIN	The Alliance or Delegate
	X3900	SINGLE MOD 1 AREA INIT 30 MIN	The Alliance or Delegate
	X3902	SINGLE MOD 1 AREA EA.ADD 15 MIN	The Alliance or Delegate
	X3904	SINGLE PROC 1 AREA INITIAL 30 MIN	The Alliance or Delegate
	X3906	SINGLE PROC 1 AREA EA. ADD 15 MIN	The Alliance or Delegate
	X3908	TREAT INCLUD COMB ANY MODS & PROCS	The Alliance or Delegate
	X3910	TREAT INCLUD COMB ANY MODS & PROCS	The Alliance or Delegate
	X3912	HUBBARD TANK INITIAL 30 MINUTES	The Alliance or Delegate
	X3914	HUBBARD TANK EACH ADDITIONAL 15 MIN	The Alliance or Delegate
	X3916	HUBBARD TNK OR POOL TX W/EXER 30 MI	The Alliance or Delegate
	X3918	HUBBARD TNK OR POOL TX W/EXER 15 MI	The Alliance or Delegate
	X3920	ANY TSTS & MEASURES INIT 30 MIN REP	The Alliance or Delegate
	X3922	ANY TSTS & MEASURES ADD 15 MIN REP	The Alliance or Delegate
	X3924	PHYSL TX PRELIM EVAL REHAB,SNF, ICF	The Alliance or Delegate
	X3936	UNLISTED SERVICES	The Alliance or Delegate
Pulmonary Therapy	**94626**	**Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)**	**The Alliance or Delegate**
Occupational Therapy	G0152	SRVC OT HOM HLTH/HOSPICE EA 15 MIN	The Alliance or Delegate
	X4100	EVAL INIT 30 MIN PLUS RPT	The Alliance or Delegate
	X4102	EVAL EA. ADD 15 MIN PLUS RPT	The Alliance or Delegate
	X4104	CASE CONF AND RPT INIT 30 MIN	The Alliance or Delegate
	X4106	CASE CONF AND RPT EA.ADDIT 15 MIN	The Alliance or Delegate
	X4108	OT TX PRELIM EVAL REHAB,NF-B, NF-A	The Alliance or Delegate
	X4110	TREATMENT INITIAL 30 MINUTES	The Alliance or Delegate
	X4112	TREATMENT EACH ADDITIONAL 15 MINUTE	The Alliance or Delegate
	X4114	HOME OR LTC FACILITY VISIT	The Alliance or Delegate
	X4116	MILEAGE / MILE 1-WAY >10 MI RADIUS	The Alliance or Delegate
	X4118	UNLISTED SERVICE	The Alliance or Delegate
	X4120	CASE CONSULTATION AND REPORT	The Alliance or Delegate
Speech Therapy	92507	SPEECH/HEARING THERAPY	The Alliance or Delegate
	92508	SPEECH/HEARING THERAPY	The Alliance or Delegate
	92521	EVALUATION OF SPEECH FLUENCY	The Alliance or Delegate
	92522	EVALUATE SPEECH PRODUCTION	The Alliance or Delegate
	92526	ORAL FUNCTION THERAPY	The Alliance or Delegate

Please note: This list does not include all services.

Important Update: Podiatry Codes that Require Authorization

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We have an important update we would like to share with you.

Our provider partner satisfaction is a top priority. We are working to improve our Utilization Management and Claims processes to help ensure proper claim payment to our provider partners, and alignment of authorized services. To accomplish this goal, we are reviewing each benefit and we will be sending you updates, as the information is ready to share.

This communication provides an update on podiatry codes that require prior authorization (PA).

This will affect claims with the date(s) of service starting Thursday, December 15, 2022, and onward. Enclosed with this notice is a code-specific list of podiatry codes that shows which codes require PA. The list can also be found on our website at **www.alamedaalliance.org/providers/authorizations**. Please refer to our website for the most up-to-date information about codes or benefits that require authorization.

In addition to the codes, our claims system will also validate that the claims received match the authorization when an authorization is required.

The following items will be validated

- Member name
- Provider NPI
- CPT and HCPC coding
- Date(s) of service are within the authorized range
- Number of units and/or visits
- Place of service matches the site of care submitted on the authorization request form

This update has been validated based on current publishable/billable coding for 2022 and was confirmed to be covered by the California Department of Health Care Services (DHCS).

If you have any questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

Thank you for your continued partnership and for providing high-quality care to our members and the community.

ALAMEDA ALLIANCE FOR HEALTH REFERRAL AND PRIOR AUTHORIZATION (PA)
PROCEDURE CODES FOR PODIATRY

Before services are provided, please check:
Member Eligibility ▪ Medical Group ▪ Benefit Coverage ▪ Contracted Provider ▪ Medi-Cal Excluded Code
Questions? Please call the Alliance Provider Services Department at **1.510.747.4510**

SERVICE CATEGORY	PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	SUBMIT AUTHORIZATION REQUEST TO
Podiatry	28285	REPAIR OF HAMMERTOE	Alameda Alliance for Health or Delegate
	28286	REPAIR OF HAMMERTOE	Alameda Alliance for Health or Delegate
	28288	PARTIAL REMOVAL OF FOOT BONE	Alameda Alliance for Health or Delegate
	28289	CORRJ HALUX RIGDUS W/O IMPLT	Alameda Alliance for Health or Delegate
	28291	CORRJ HALUX RIGDUS W/IMPLT	Alameda Alliance for Health or Delegate
	28306	INCISION OF METATARSAL	Alameda Alliance for Health or Delegate
	28307	INCISION OF METATARSAL	Alameda Alliance for Health or Delegate
	28308	INCISION OF METATARSAL	Alameda Alliance for Health or Delegate
	28315	REMOVAL OF SESAMOID BONE	Alameda Alliance for Health or Delegate
	28360	RECONSTRUCT CLEFT FOOT	Alameda Alliance for Health or Delegate
	28899	FOOT/TOES SURGERY PROCEDURE	Alameda Alliance for Health or Delegate
	L2006	KAF DVC ANY MATERIAL ADJ CUSTOM FAB	Alameda Alliance for Health or Delegate
	L3000	FT INSRT MOLD UCB TYPE BERKLY SHELL	Alameda Alliance for Health or Delegate
	L3160	FOOT ADJUSTBL SHOE-STYLD PSTN DEVC	Alameda Alliance for Health or Delegate

Dear Valued Provider,

At Alameda Alliance for Health (Alliance), we appreciate you and the quality health care you provide 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.

To help support our provider's focus on substance use disorder, chronic pain, and opioid and benzodiazepine usage, the Alliance has developed several provider materials for usage:

Provider Tools

- Opioid Tapering Tool
- Benzodiazepine Tapering Tool
- Non-Opioid Alternatives on the Alliance Formulary
- Opioid Dependence Treatment

Member Tools

- Opioid Safety Guide

To find a local pain specialist or alternative treatment provider, please refer to the Alliance Provider Directory on our website at **www.alamedaalliance.org.**

On a routine basis, we will mail a list of your patients who:

- Visit the Emergency Department for opioid and/or benzodiazepine overdose
- Concurrently utilize opioids and benzodiazepines
- Are identified as chronic opioid users
- Are identified as a rising risk for substance use disorder (SUD)

If you have any questions or want to request a copy of the other tools, please contact us by using the information provided below.

As always, thank you for your continued partnership and for providing high-quality care to our members and community. Together, we are creating a healthier community for all.

Sincerely,

Sanjay Bhatt, MD
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